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PAPER

Conscientious objection to abortion in Italy: what should we do when too many doctors object?

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ABSTRACT

The law regulating abortion in Italy gives healthcare practitioners the option to make a conscientious objection to activities that are *specific* and *necessary* to an abortive intervention. Conscientious objectors among Italian gynaecologists amount to about 70%. This means that only a few doctors are available to perform abortions, and therefore access to abortion is subject to constraints. In 2012 the International Planned Parenthood Federation European Network (IPPF EN) lodged a complaint against Italy to the European Committee of Social Rights, claiming that the inadequate protection of the right to access abortion implies a violation of the right to health. In this paper I will discuss the Italian situation with respect to conscientious objection to abortion and I will suggest possible solutions to the problem.

IS CONSCIENCE A PROBLEM IN MEDICINE?

The issue of conscientious objection of health medical professionals is one of the most puzzling and yet urgent topics in the current debate in bioethics. A notable number of medical healthcare practitioners ask (and are often legally permitted) to be exempted from doing what, as professionals, they are ordinarily expected to do. Most of these claims concern reproduction—for instance, those put forward by healthcare practitioners who refuse to perform abortions or to fill prescriptions for morning after pills.

One objection to recognising this right is that granting medical professionals such exemptions can prevent patients from getting easy and efficient access to the treatment they need. A common response to this concern is that this complaint is overblown and that there will always be enough doctors who are willing to help the patients. However, there is at least one concrete example that clearly shows that this complaint is not overblown: Italian laws concerning abortion and conscientious objection.

In this paper I will introduce the Italian legislation on abortion, and I will explain why the current regulation of conscientious objection to abortion damages women who need a termination of pregnancy. At the end of the paper, I will suggest some strategies that would better serve patients without unduly burdening healthcare professionals.

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THE LIMITS OF THE LAW REGULATING ABORTION IN ITALY

Abortion was legalised in Italy through Law No194 of 1978. Article 9 of that law introduces the right to conscientious objection for the health personnel involved in activities that are *specific* and *necessary* to an abortion, but not to activities that are performed *before* or *after* the abortion.[1]

It is important to notice that in Italy, contrary to what happens in other countries, abortions can only be performed by gynaecologists and obstetricians, and never by general practitioners (GPs), even when the abortion is achieved pharmaceutically through the use of RU486 (mifepristone). This means that the number of professionals who can perform abortions is relatively small compared with in countries where no specialisation in gynaecology or obstetrics is required to perform an abortion.

A few points of Law 194 of 1978 need a more detailed explanation.

1. Rather than clearly specifying which professional categories among healthcare personnel can object and which activities can be objected to, the law says that health personnel (in general) can object to performing activities that are specific and necessary to an abortion, but not to activities that are performed before and after the abortion. Needless to say, the 'specific and necessary' as well as the 'before and after' criteria have been interpreted quite differently by different doctors.

For instance, in April 2013 the Court of Appeal of Trieste[2] sentenced a doctor to 1 year of imprisonment for refusing to assist a patient who, after using RU486, was encountering problems in expelling the placenta. The nurses, worried that this could lead to bleeding, asked the doctor to intervene, and so did the head of the medical division, giving her instructions on the phone. Eventually, since the doctor could not be persuaded to change her mind, the head of the medical division had to go to the hospital (out of his work shift) and help the patient with the placenta expulsion.

Article 9 of Law 194 of 1978 states that conscientious objection cannot be used when there is an immediate danger of death of the woman. This is because, as stated by the Italian Constitutional Court (Judgement No 27 of 1975) 'there is no equivalence between the right not only to life, but also to health of the one who is already a person, like the mother, and the safeguarding of the embryo, which still has to become a person'.[i]

The doctor who refused to help the woman claimed not to be chargeable because the patient was not in immediate danger of death. However,

[i]My translation from Italian.

the judge pointed out that she was not entitled to refuse to intervene, as the activity she was asked to perform was not part of the procedure meant to cause the abortion, but it rather had to be performed after the abortion itself.

However, this particular doctor seemed to consider the expulsion of the placenta as specific and necessary to the abortion, and she is certainly not the only one to interpret the law more broadly than the Trieste judges did.[3] I do not intend to suggest that the narrow interpretation of the Court of Appeal of Trieste is more or less accurate, or overall better or worse than the broad interpretation. But I do suggest that the law should be changed so as to clearly explain which activities ought to be considered specific and necessary to an abortion and which ones ought to be considered as merely something performed before or after the abortion.

2. The second aspect not sufficiently explained in the legislation is how hospitals and regional authorities are supposed to guarantee safe access to abortion if the number of conscientious objectors is too large. As shown in table 1, the percentage of conscientious objectors in Italy among gynaecologists, obstetricians, anaesthetists and ancillary personnel is very high, and it has increased overall over the last 13 years. So, although the law says that abortion should be guaranteed by mobilising healthcare personnel, it does not say what should be done when there are not enough practitioners in the whole country willing to perform abortions.

THE COMPLAINT OF THE PLANNED PARENTHOOD FEDERATION EUROPEAN NETWORK AGAINST ITALY

In 2012 the International Planned Parenthood Federation European Network (IPPF EN) lodged a complaint against Italy (Complaint No 87/2012) to the European Committee of Social Rights.[4]

The complaint alleged a violation of the right to health (Article 11 of the European Social Charter) due to inadequate protection of the right to access procedures for the termination of pregnancy. In particular, the IPPF EN pointed out that Article 9 of Law No 194 does not explain how to guarantee women safe access to abortion when there are not enough healthcare practitioners to perform the intervention.

Table 1 Percentage of conscientious objectors among gynaecologists, anaesthetists and auxiliary personnel in Italy from 1997 to 2010

	Gynaecologists	Anaesthetists	Auxiliary personnel
1997	62.8	53.3	54.3
1998	64.1	53.9	55.5
1999	64.8	50.3	55.5
2000	67.4	54.7	53.9
2001	66.6	54.1	50.4
2002	60.4	48.6	40.4
2003	57.8	45.7	38.1
2004	59.5	46.3	39.1
2005	58.7	45.7	38.6
2006	69.2	50.4	42.6
2007	70.5	52.3	40.9
2008	71.5	52.6	43.3
2009	70.7	51.7	44.4
2010	69.3	50.8	44.7

In February 2013 the European Committee of Social Rights declared the complaint admissible. The Committee has not yet pronounced a final judgement, but it is important to analyse the Italian situation and to understand why it evolved in such a way that prompted IPPF EN to ask the European Committee to intervene.

Apart from introducing the 'specific and necessary' and the 'before and after' parameters, and apart from clearly stating that conscientious objectors must help patients when there is an immediate risk of death, Article 9 states that 'in all cases, hospitals, establishments and authorised nursing homes will be required to ensure that procedures are carried out in accordance with the measures prescribed by the law. In particular, all regions must guarantee access to abortion, even using mobility of personnel if in a particular area there is no doctor willing to perform an abortion'.[ii]

However, in a region where there are only a few gynaecologists available to perform abortions, it is difficult to organise the work shifts of the few non-objecting doctors so as to make access to abortion quick and efficient. Moreover, should conscientious objection rates hit 100% among the healthcare personnel, it would not be possible to use mobility at all. In such a scenario, it would be just theoretically, but not practically, possible to obtain an abortion in Italy. At the moment, we can reasonably argue that, given the current extremely high percentage of conscientious objectors, access to abortion is, to say the least, extremely difficult.

ADDITIONAL INFORMATION ABOUT THE ITALIAN SITUATION

The complaint does not discuss some additional pieces of information that are nonetheless important in trying to properly understand the Italian situation.

1. The Ministry of Health does not consider the possibility that such a high percentage of conscientious objectors could cause delays and inefficiencies, but states instead that access to abortion is always guaranteed within the first trimester.[5] However, the Ministry does not take into account the fact that many women need to go to France or to the UK in order to obtain an abortion. For instance, the number of Italian women seeking an abortion in Nice is so large that the city's hospital has decided to no longer accept Italian patients. It is not at all clear why all these women would travel to Nice (or to the UK and other European countries) if it were so easy to obtain an abortion in Italy.[6]

The Ministry states that the rate of abortion in Italy is among the lowest in Western countries.[5] But this does raise some questions. Maybe the number of abortions is comparatively small because there are many women who travel abroad to obtain them, and not because Italian women become (unwillingly) pregnant less often than women in other Western countries. In support of this hypothesis, there is also the fact that, apparently, the number of backstreet abortions has been increasing in the last few years. One of the most important Italian newspapers, *La Repubblica*, recently published a journalistic inquiry about conscientious objection in the country.[7] The inquiry reports that the official data from the Ministry of Health estimates that there are about 20 000 backstreet abortions per year (last data available refer to 2008), but that the real number is probably much larger (40 000/50 000). According to ISTAT (National Institute

[ii]My translation from Italian.

of Statistics), over the last 30 years, the number of miscarriages increased by 30%, going from 55 000 in the 1980s to about 80 000 today.[8] A plausible explanation of this increase is the spread of backstreet abortions (for which data are of course difficult to collect), both through the use of mifepristone bought on the internet or the black market and those performed in private (and illegal) medical centres. These abortions often cause bleeding, and women go to the hospital claiming that they have just had a miscarriage. This may explain the data on the fall in abortion rates and the increase in (alleged) miscarriages.

2. In addition to terminations of pregnancy that are performed because the woman is not willing to have a child, there are terminations performed after 90 days of pregnancy because the fetus is affected by anomalies. Conscientious objectors can also refuse to perform the latter type of abortion (ie, therapeutic abortions). Even when the pathology is so severe to be considered not compatible with life, healthcare practitioners can refuse to be involved in the procedure. For therapeutic abortions also, many women prefer to go abroad. The reason may be that many women who have been through this procedure claim they were treated 'inhumanely' by the healthcare personnel, as is narrated in books and blogs collecting these stories.[9] Moreover, since women know that there are many conscientious objectors among the healthcare personnel, it is plausible that they prefer to avoid dealing with possible delays and inefficiencies.
3. Finally, it is important to understand why the number of conscientious objectors is constantly increasing. Italy is a Catholic country, and doctors who perform abortions are, by default, condemned by the Catholic Church to a latae sententiae excommunication.[10] But it would be naive to think that this is the only reason why conscientious objection is so widespread. There are many cases of doctors who were hired as non-conscientious objectors, but who changed their mind after a few (or many) years performing abortions, and such numerous and sudden conversions to Catholicism should raise some suspicion.[11] One hypothesis is that, as only a few doctors perform abortions, the non-conscientious objectors spend all their time performing abortions without having the opportunity to participate in other medical practices they might enjoy more. Besides, if the director of the medical division is also a conscientious objector (as in the majority of cases), it is better, career-wise, to be a conscientious objector too. Another reason for thinking that religious concerns are not the only reason why healthcare practitioners decide to object is that there are conscientious objectors who do not perform abortions in the hospitals by which they are employed, but do perform abortions in private clinics (thus violating the law, according to which abortions can only be performed in authorised hospitals and clinics). In 2008, for instance, a gynaecologist who was officially a conscientious objector committed suicide after being charged for performing backstreet abortions in his private practice.[12] At the moment, 188 Italian gynaecologists are involved in legal trials for performing abortions in private practice.[7]

The reasons why a doctor chooses conscientious objection may vary, but it is interesting to note that healthcare practitioners have reported on the stigma attached to them for practising abortions.[13]

For the same reason, many gynaecologists only start their career as conscientious objectors. Indeed, once someone has a degree in medicine, they can decide to be a conscientious objector as soon as they start their specialisation in gynaecology or anaesthesiology. This also means that many students are not sufficiently trained, during their specialisation period, to perform abortions. Once again, there is a real risk that abortion will be possible only in theory, and not in practice, since there will not be doctors able to perform these interventions.

COMMON APPROACHES TO THE PROBLEM

The literature on conscientious objection has been broken down as follows[14]: (1) the incompatibility thesis; (2) conscience absolutism; (3) compromise or 'the moderate view' (MV).[15]

According to (1), doctors have no right to refuse to perform a treatment that a patient may request because being a medical healthcare practitioner is not compatible with conscientious objection.

In contrast, according to (2), healthcare practitioners are entitled to refuse to treat a patient even when such a refusal can compromise the right of the patient to be cured.

Finally, the compromise approach or MV (3) states that healthcare practitioners can refuse to perform a certain activity but they need to refer their patients to a willing colleague.

The MV is by far the most widely shared in the ethics literature[14 16] and by legislation regulating conscientious objection to abortion. The reason the MV is the consensus view is that it seems to strike a balance between the need of the patient to obtain the treatment and the request of doctors not to be forced to act against their conscience. If a medical care practitioner promptly refers the patient to a willing colleague so that the patient can easily obtain the required treatment, conscientious objection would pose no problem. However, this idea might seem good in theory, but, in practice, things are not so simple.

For instance, the MV does not take into account contexts where the percentage of conscientious objectors is extremely high, so that the referral is hardly easy and efficient. If a patient is not directly referred to a willing doctor—that is, if the conscientious objector does not provide her with the name and address of a willing colleague—it is very likely that the patient will receive many refusals before actually obtaining the treatment they need. In particular, if the treatment is urgent (as in the case of emergency contraceptives), it can be impossible for a patient to find a willing doctor in time. Moreover, if the woman lives in a remote area where only a few practitioners are available, and if for any reason she cannot travel, it can be extremely difficult, if not impossible, for her to find and reach a doctor who will provide the treatment.

So, overall, the MV protects patients only in areas where the referral is efficient because there are only a few conscientious objectors. However, a solution that works only where there is no practical problem is, quite obviously, not a good one.

Moreover, the MV fails to adequately safeguard the moral integrity of doctors if they are forced to deal with a referral and be accomplices in (what they consider) wrongdoing for their patients.[iii] However, this is an issue that cannot be addressed in this paper. For the aims of this paper, it is important to point out that, in areas with a high percentage of conscientious objectors, the MV does not provide a very useful solution. In the next paragraph I am going to suggest possible strategies that would help improve the situation in Italy and other countries with a high percentage of conscientious objectors.

[iii]For a detailed discussion on this point, see Minerva, F., Conscientious Objection and Cooperation in Wrongdoing: a New Approach to an Old Problem, (under review).

POSSIBLE PRACTICAL SOLUTIONS

So far, I have shown that, as pointed out in the complaint lodged by IPFF EN to the European Commission of Social Rights, the law governing conscientious objection in Italy is not adequate to safeguard the well-being of patients. In particular, the extremely high percentage of conscientious objectors prevents timely and safe access to abortion, especially in some regions of Italy (such as Sicily, Lazio and Basilicata) where the percentage of conscientious objectors reaches 80% among gynaecologists.

It is beyond the goals of this paper to discuss whether conscientious objection to abortion is morally acceptable and/or whether it should be legally permissible. However, I want to suggest some practical solutions that would allow patients to have access to safe and timely abortion while still allowing healthcare personnel to make a conscientious objection (within some limits).

The following are possible ways to improve the situation.

1. As in other countries, GPs could be involved in early term abortions. As there are more GPs than gynaecologists, even if the percentage of conscientious objectors among GPs was as high as among gynaecologists, there would still be more people capable of and willing to perform early term abortions.
2. Conscientious objection could be discouraged in different ways—for example, by offering better salaries to non-conscientious objectors or more holidays. As non-conscientious objectors perform activities that the majority of their colleagues refuse to perform, it seems fair to reward them with some incentives.
3. Each hospital, or all the hospitals in a certain geographic area, should guarantee an ideal ratio of conscientious objectors to non-conscientious objectors. Empirical studies should be conducted to assess the ideal ratio of objectors to non-objectors. Until these studies are available, it is safe to claim that at least 50% of nurses, gynaecologists, obstetricians and anaesthetists in each Italian hospital, or in all the hospitals in a limited geographic area, should be non-objectors. In order to maintain the (to be assessed) right proportion, the hospital should be entitled to terminate employment of a doctor who, hired as a non-objector, decides to make a conscientious objection after she/he has been employed. At the least, this measure should be taken in order to replace the conscientious objector with a non-conscientious objector when the established ratio would be compromised by allowing a willing doctor to become a conscientious objector.

These strategies would work best if Article 9 of Law 194 of 1978 were modified so as to explain clearly which activities should be considered specific and necessary to the abortion.

CONCLUSIONS

When Law 194 of 1978 became effective, people who had entered the medical career before 1978 claimed that they could not have foreseen that abortion was going to become a legal procedure, so Article 9 was intended to protect the autonomy and moral integrity of these people. However, 35 years later, someone who chooses to become a gynaecologist, a nurse or an anaesthetist knows that abortion is a treatment that they could be asked to perform during their career. Although it is, at least prima facie, important to respect the conscience of the health personnel involved in abortions,[17] and although requests for conscientious objection should be accommodated when it is possible to do so without damaging the patients,[18] the public health system has the responsibility and duty to guarantee to citizens all the safe and beneficial treatments they are entitled to request. After all, a public health system is largely supported by taxation of people who, in turn, are entitled to have access to treatments they need and pay for. It might be open to discussion whether private hospitals should be able to choose what kind of treatment to offer their patients; however, publicly funded hospitals have different duties and responsibilities from private ones. When conscience-related issues prevent access to a certain treatment, such as abortion in Italy, the public health system, or the Ministry of Health in this case, has to find a solution that safeguards and protects the health of the patients as a priority. The solutions suggested in this paper are intended to open a debate about the most adequate and efficient way to deal with this kind of conflict.

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