



**COMPARATIVE LEGAL ANALYSIS OF CONSCIENTIOUS OBJECTIONS
IN HEALTH CARE**

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ABSTRACT

The purpose of this thesis is to demonstrate what would be an appropriate model of the regulation of conscientious objections in health care. These objections are regulated in many countries' national legislations, however, some of them fail to provide safeguards which would secure proper balance between the two conflicting interests – the health care professional's right to act in accordance with his conscience and individual's right to access health care.

Therefore, this thesis analyzes regulation of the conscientious objection in the legal systems of the USA, the UK and the Slovak Republic with respect to the appropriateness of such regulation and major differences which they include. The thesis suggests that the protection of conscientious objection in the USA can go too far and be too excessive, while the UK presents much more appropriate model of regulation of conscientious objection with certain limitations. Furthermore, it submits that regulation of conscientious objection in Slovakia consists in general but vague clause creating the possibilities for future controversies.

The thesis also analyses different opinions on the acceptability of conscientious objection in health care and finally, it suggests conditions and limitations of conscientious objection that should be met in the regulation of national legislations in order to find appropriate balance between the competing interests of health care professionals and patient.

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INTRODUCTION

Being a hot topic of discussions, conscientious objection is challenging but not a new term to discuss. Although, originally appeared with respect to performance of military services, it quickly penetrated into the other areas of human life. Yet, probably the most controversial of them being the area of health care. One is not surprised why. Human life and thus consequently health are the most precious values in possession of human beings. People can have many dreams, possess many material things but none of them can equal health and life.

Conscientious objection in health care does not only go deeply into the heart of medicine and law but also the medical ethics. Two competing interests are placed against each other. On the one hand, there is an interest of the health care professional to act or not to act in accordance with his conscience on the other, there is an interest of the patient to receive a particular health care service or treatment. Patients are dependant on health care professionals' knowledge with respect to health issues and reciprocally health care professionals bear the professional responsibility towards them.

Therefore, it is necessary to approach these objections very carefully and responsibly so that the objection relating to the patient's treatment will not have a negative influence on the patient rights. These objections can be based on different grounds – however, religious beliefs tend to be the most common ground for invoking such objection. Many of these objections can be lawful and reasonable, but on the other hand if they are used extensively they result in abuse of the right to conscientiously object and cause discriminative behavior towards the patients resulting in patient not having access to the legally available health care services to which they are entitled.

The opinions on whether it should or should not be allowed and if so to what extent vary. The disparity of opinions is significant. While some opinions suggest that conscientious objections do not have a place in contemporary medicine at all, others are not so clear-cut and rather suggest compromise. For example, Savulescu considers that conscientious objection in health care should be illegal and that it is the law which stipulates which health care services are legally available to people and thus they should be provided.¹ Other authors, such as for example Farr A. Curlin, believe that there is a place for conscientious objection in health care and that for the health care professionals to refuse delivery of treatment contradicting with their conscience. However, at the same time he emphasizes that health care professionals still have a duty to inform and refer a patient who approached them².

However, even though these opinions are well-founded, it must be remembered that the conscientious objection is not a phenomenon that has not appeared yet in practice but on the contrary, it is already being invoked in the sphere of health care either in the broader or narrower scope. As will be shown in this thesis, the USA has a heterogeneous regulation of the conscientious objection clauses and in certain cases such as the Mississippi one going too far and offering the chance for the abuse of the conscientious rights³, on the other hand United Kingdom's laws include limitation on the conscientious objection⁴ and in the example of Slovakia, typical post-communist country, the national legislation regulates the refusal of treatment or procedure on the basis of health worker's conscience - however, in general way

¹ J. Savulescu, "Conscientious objection in medicine", *BMJ* 2006, 332, 294-297, last accessed on March 16, 2010 at: <http://www.bmjjournals.org/cgi/content/full/332/7536/294?ijkey=6NtRebQvp8GVGYn&keytype=ref>

² Curlin, FA, et al. "Religion, Conscience and Controversial Clinical Practices." *NEJM*. 356;6:593-600 in Medical Ethics Advisor, "Should health care providers have the right of conscientious refusal?", December 2009, Vol. 25, No. 12, p. 133-144, p. 135

³ Mississippi Health Care Rights of Conscience Act 2004, Section 2(a), 2(b), 3(2) and 3(3) last accessed on March 13, 2010 at: <http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm> further analyzed in Chapter 2.1. of this paper

⁴ Abortion Act 1967, section 4(1) and 4(2), last accessed on March 20, 2010 at: <http://www.statutelaw.gov.uk/documents/1967/87/ukpga> further analyzed in Chapter 2.2. of this paper

which can raise lots of issues in the future⁵. Thus, despite various conscientious objection clauses which appear in the national legislations of particular states, it seems that majority of these provisions do not regulate the conscientious objection usage sufficiently.

Because of that, discussion should be about not whether it should be allowed but rather to what extent, with what limitations and in how broad scope in order to find the fine balance between competing interests. Thus, it is important to keep in mind this fact and try to find the most suitable way for regulation of these objections which would on the one hand safeguard the individuals timely and proper access to the legally available reproductive health care services in the country while on the other hand would not compel doctors to act contrary to their conscience, of course at the same time respecting the fact that care about the patients is in the first place.

As the area of health care is broad, in my thesis I will analyse the conscientious objections in its most controversial sphere - reproductive services – especially with respect to the refusal to provide the abortion procedures and emergency contraception. Another controversial issue of these days are the end-of-life decisions, however, these will not be discussed in this paper.

Thus, the aim of this paper is to analyse the appropriateness of the regulation of conscientious objections with respect to reproductive health care services in the legislation of the United States of America, the United Kingdom and the Slovak Republic. It will be shown that the US protection of conscientious objection can go too far and thus is too excessive, that the UK presents much more appropriate model of regulation of conscientious objection with certain

⁵ Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Appendix 4 - Code of Ethics of the Medical worker, clause 3, available at: http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm further analyzed in Chapter 2.3. of this paper

limitations and that the Slovak regulation consisting in general and vague clause that opens the possibilities for future controversies. Based on these findings, appropriate model for regulation of conscientious objection will be offered.

This paper is divided into three chapters, from which the first one explains the grounds for conflict of interests arising between the health care professional's right to conscientiously object and patient's right to access to health care. The second one analyzes the regulation of the conscientious objection in the legal systems of the USA, the UK and Slovakia, by referring to state legislations and expert articles. Finally, the third chapter provides an overview of the different opinions to acceptability of conscientious objection in health care and suggests the appropriate model of its regulation by setting up conditions that should be fulfilled by states regulations on conscientious objection.

CHAPTER I

Conscientious objection and conflict of interests

Conscientious objection was traditionally perceived within the context of military services, when the individual refused to take part in military service on the basis of his conscience, claiming internationally recognized “freedom of thought, conscience and religion”.^{6,7}

However, this is not the only field where the freedom of conscience can be invoked. This freedom spread also into the sphere of health care by giving the health care professionals the right to object towards particular treatment or health care service and refuse to perform them.⁸

Provisions on conscientious objections usually allow for health care professionals to refuse to perform or take part in certain procedures on the basis of religious, moral or ethical beliefs, though many of the conscientious objections are based on religious grounds.⁹ Medical procedures where conscientious objections appear most frequently are those related to reproductive services, such as for example abortion, emergency contraception, family-planning services or those related to end-of-life decisions.¹⁰

The regulation of conscientious objections in the reproductive health care services varies. In some states the comprehensive conscience laws were enacted where the regulation of the

⁶ Framework for Communications, Conscientious objection , Freedom of Religion or Belief, Human Rights Committee general comment 22, para. 11, Office of the United Nations High Commissioner for Human Rights, last accessed on March 17, 2010 at: <http://www2.ohchr.org/english/issues/religion/I3k.htm>

⁷ International Covenant on Civil and Political Rights entry into force 23 March 1976, in accordance with Article 49, Article 18, Office of the United Nations High Commissioner for Human Rights, last accessed on March 17, 2010 at: <http://www2.ohchr.org/english/law/ccpr.htm>

⁸ Supplementary Guidance of the General Medical Council on Personal Beliefs and Medical Practice, last accessed on March 17, 2010 at: http://www.gmc-uk.org/static/documents/content/Personal_Beliefs.pdf

⁹ B.M.Dickens, Conscientious objection and professionalism, *Expert Rev. Obstet. Gynecol.*, 4(2), 97-100 (2009), last access on March 20, 2010 at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1372865

¹⁰ A.Grandy, “Legal Protection for Conscientious Objection by Health Professionals”, *Virtual Mentor, Ethics of Journal of the American Medical Association*, May 2006, Volume 8, Number 5: 327-331, last accessed on March 16, 2010 at: www.virtualmentor.org

scope and extent of the usage of conscientious rights is very broad, such as US Mississippi¹¹, in others – such as the United Kingdom¹² conscientious clauses became a part of particular Acts related to controversial health care service and are limited by the scope to which they apply, subjects who can invoke them and similar. There are also states such as Slovakia¹³ that have very general rules on the use of conscientious objections applicable to any legally available health care services.

In practice, the problem arises when the use of contentious objection by the health care provider or health care professional collides with the right of the patient to the access to legally available health care service including right to receive information on his health status, diagnosis, prognosis and possible treatments. Raising conscientious objection by the health care professional is not just a matter of his concern but also becomes a significant issue for individual's requesting medical treatment or in a need of health care service. This is because when conscientious objection is raised, the rights of both - persons invoking it as health care professionals and those towards whom it is directed as patients or individuals requesting the treatment - are at stake.

It is generally known that any limitation of access to health care that can be caused by the exercise of conscientious objection right can have an adverse impact on the individual seeking the health care service. This is because in such case the rights of health care professionals are placed against the rights of the individuals. Thus, in the next section I will introduce the sources of conflict of interests between the Health care professional and Patient stemming

¹¹ Mississippi Health Care Rights of Conscience Act 2004, last accessed on March 13, 2010 at:
<http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm>

¹² Abortion Act 1967 c87 , last accessed on March 20, 2010 at:
<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

¹³ Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Anex 4, Code of Ethics of Health Worker to be seen at:
http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm

from Health care professional's right to conscientiously object and the Patient's right to access health care.

1.1. Health Care Professional's right to conscientiously object

The roots of the right to conscientiously object towards the exercise of certain medical treatments or provisions of health care service can be found in the internationally recognized instruments as well as in domestic legislations. These instruments regulating the framework for the conscientious objections were ratified by majority of states, the most renowned but not the only one being for example: The Universal Declaration of Human Rights¹⁴, the International Covenant on Civil and Political Rights (hereafter referred to as "ICCPR")¹⁵, the International Covenant on Economic, Social and Cultural Rights (hereafter referred to as "ICESCR")¹⁶, Convention on Elimination of All Forms of Discrimination Against Women (hereafter referred to as "CEDAW")¹⁷. They regulate fundamental human rights and freedoms relating to conscientious objections, such as for example the "right to freedom of conscience, thought and religion"¹⁸ or the "right to the highest attainable standard of health"¹⁹⁻²⁰⁻²¹ often

¹⁴ The Universal Declaration of Human Rights (1948), accessed on March 18, 2010 at:
<http://www.un.org/en/documents/udhr/>

¹⁵ International Covenant on Civil and Political Rights, entry into force 1976, Office of the United Nations High Commissioner for Human Rights, last accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/ccpr.htm>

¹⁶ International Covenant on Economic, Social and Cultural Rights, entry into force 1976, Office of the United Nations High Commissioner for Human Rights, last accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/cesr.htm>

¹⁷ Convention on the Elimination of All Forms of Discrimination Against Women, Division for the Advancement of Women, Department of Economic and Social Affairs, last accessed on March 18, 2010 at:
<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

¹⁸ Article 18 of The Universal Declaration of Human Rights, last accessed on March 18, 2010 at:
<http://www.un.org/en/documents/udhr/>

¹⁹ Article 12 of The International Covenant on Economic, Social and Cultural Rights, Office of the United Nations High Commissioner for Human Rights, lastly accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/cescr.htm>

²⁰ Article 25 of The Universal Declaration of Human Rights, last accessed on March 18, 2010 at:
<http://www.un.org/en/documents/udhr/>

²¹ Preamble of the Constitution of the World Health Organization, lastly accessed on March 18, 2010 at:
<http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

referred to as the ‘right to health’. Thus, provisions on the ‘freedom of conscience, thought, and religion’ provide the basic ground for conscientious objections.

Specifically, the Universal Declaration of Human Rights provides for the ‘freedom of thought, conscience and religion’ in Article 18, which stipulates that: “*Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*”²²

A similar provision is included in Article 18(1) of the ICCPR²³. However, while the general right to ‘freedom of conscience, religion and thought’ can not be limited, their manifestation is subject to certain limitations as provided for in Article 18(3) of the ICCPR. The grounds for such limitations are the protection of health, morals and rights of others.²⁴

The last one mentioned – the necessity to balance the right to ‘freedom of thought, conscience and religion’ with the ‘rights of others’ was recognized even by the former head of the Catholic Church - pope John Paul II – who, with respect to Article 18(3) of the ICCPR, expressed that freedom of conscience should be guaranteed by the State but is not unlimited. With regards to this, he made a statement that in cases when the freedom of conscience would be abused for limiting the rights of the others it is for the State to protect the rights of its respective citizens.²⁵

²²Article 18 of the Universal Declaration of Human Rights, accessed on March 18, 2010 at:
<http://www.un.org/en/documents/udhr/>

²³ Article 18(1) of The International Covenant on Civil and Political Rights, Office of the United Nations High Commissioner for Human Rights, last accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/ccpr.htm>

²⁴ Ibid., Article 18(3)

²⁵ John Paul II - Message for the 24th World Day of Peace 1991, para. 24, “If You Want Peace, Respect the Conscience of Every Person,” which stipulates: “It should be noted that freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into licence or

The right of Health Care Professionals to conscientiously object is closely related with the individual's integrity. As Article 1 of the Universal Declaration on Human Rights stipulates, “*All human beings ... are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.*”²⁶ It is exactly this reason and conscience that constitute human beings' personal integrity. One must admit that both of them, reason and conscience, influence each person's decisions and if the person is forced to act contrary to his conscience, such pressure can weaken the understanding of one's integrity, cause the feeling of guilt and destroy one's self-respect and self-belief.²⁷

Besides the above-mentioned international instruments that regulate the contentious rights, the particular right of health care professionals to contentiously object in health care is also regulated by the national legislations of individual states either in wider form or more narrowly. The extent and scope of the contentious clauses in different legal systems vary, with the differences consisting mainly in the details of the regulation and the scope of actions and services towards which the objections apply. These differences and analysis of the contentious objections legislation with respect to health care services are described in Chapter 2 of this paper.

becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses”, lastly accessed on March 18, 2010 at:

http://www.vatican.va/holy_father/john_paul_ii/messages/peace/documents/hf_jp-ii_mes_08121990_xxiv-world-day-for-peace_en.html

²⁶ Article 1 of The Universal Declaration of Human Rights, last accessed on March 18, 2010 at:

<http://www.un.org/en/documents/udhr/>

²⁷ American Academy of Pediatrics , “*Policy Statement – Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience*”, *Pediatrics* Volume 124, Number 6, December 2009, p1689-1693, p.1690, accessed on March 10, 2010 at:

<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/6/1689.pdf>

1.2. Patients' right to access to health care

As Dr. Bert Hermans, an Associate Professor at the Erasmus University Rotterdam points out, patients' rights can be divided into individual rights and social rights with the right to health care being the most significant social patient right. States are obliged to provide these social rights as included in particular provisions and these rights are supposed to safeguard the individual's rights.²⁸

To secure the rights of patients many legal rules evolved. The rights of patients and their pivotal position in the health care were recognized by various international treaties and agreements,²⁹ as well as by the national legislations of the particular states either in the form of Acts of Parliaments or in the form of Patients' Charters.³⁰ Thus, the legal basis of patients' rights was established.

Once the relationship of the health care professional and the patient is established, the conflict arises between the health care professional's right to conscientious object and the patient's right to access health care when the professional invokes objection based on his conscience. Besides conscientious rights having the basis in international and national instruments as already mentioned in section 1.1. of this paper, the patients' right to health is also recognized in such instruments.

²⁸ Yearbook of European Medical Law 2005, The Institute of Medical Law The Impact of Recent European Case Law and Legislation on Patients' Rights and Cross-Border Health Care, p. 17-37

²⁹ Such as for example: the European Social Charter of the Council of Europe (1961), European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), Declaration on the Promotion of Patients' Rights (1994 Amsterdam), Convention on Human Rights and Biomedicine (1999)

³⁰ Ibid., Footnote 28

The right to access health care is a part of the right to health. The right to health is a fundamental right of all people regardless of their race, religion, societal, political or other status or personal identification. Recognized in various international instruments, such as for example the ICCPR or CEDAW, it provides for the “*Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*”³¹⁻³² often referred to as the ‘Right to Health’ or ‘Right to the highest attainable standard of health’.

As was specified in the report of the UN Special Rapporteur on the right to the highest attainable standard of health, this right includes not only the right to healthcare, but also the right to the essential conditions of health.³³ In reaching such conditions, the States’ Governments play an important role. As the Special Rapporteur further explains in his report, for the effective protection of these rights they must be easily reachable for people no matter whether they live in rural or urban areas. Furthermore, they must be of a sufficient quantity and their good quality is also necessary.³⁴

Another imminent part of this right is the “right to receive information”³⁵ about the health issues which is also the one violated when health care professional refuses to perform specific treatment on the basis of conscience. This is because many of the conscientious objectors

³¹ Article 12, The International Covenant on Economic, Social and Cultural Rights, Office of the United Nations High Commissioner for Human Rights, lastly accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/cescr.htm>

³² Preamble of the Constitution of the World Health Organization, lastly accessed on March 18, 2010 at:
<http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

³³ E/CN.4/2005/51/Add.2, Report of the Special Rapporteur, Paul Hunt, Addendum: Mission to Peru on the right to the highest attainable standard of health, 2005, available at:
<http://www.un.org/esa/socdev/enable/rights/ahc7srhealth.htm>

³⁴ International Federation of Health and Human Rights Organisations, “Our Right to the Highest Attainable Standard of Health“, University of Essex, Human Rights Centre, p. 3, available at:

http://www.essex.ac.uk/human_rights_centre/research/rth/docs/REVISED_MAY07_RtH_8pager_v2.pdf

³⁵ Ibid.

refuse not only to perform or participate in a particular treatment to which they object, but also to inform a patient on his diagnosis, prognosis or possibilities of further treatment.³⁶

As the right to health is one of the fundamental human rights, it is a right that all people should enjoy. Thus, a functioning system of health protection must be established in order for people to have equal opportunities to enjoy the highest attainable standard of physical and mental health regardless of their sex, race, religion, age, disability, sexual orientation, political status or any other specification and identification.³⁷

Moreover, the Special Rapporteur brings to attention the fact that the State has the main legal responsibility for safeguarding the right to health. However, health professionals can influence securing of the right to health, as well. The more they obey the patients' right to access to legally available health care services, the more they contribute to fulfillment of this right. Furthermore, for the successful fulfillment and exercise of the right to health, those responsible for securing this right should be made accountable through the effective, transparent and accessible mechanism on the type of which the State itself can decide.³⁸

As was mentioned earlier in this section, the Right to Health generally includes the right to access to various health care services in order to protect the individual's right to the highest attainable physical and psychical health standard. And thus, sexual and reproductive health also forms an integral part of the 'right to the highest attainable standard of health'.³⁹

³⁶ See Chapter 2

³⁷ Report of the UN Special Rapporteur on the Right of everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. No. A/HRC/7/11 (2008), para. 42, lastly accessed on March 18, 2010 at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement>

³⁸ Report of the UN Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. No. A/HRC/7/11 (2008), para. 100, lastly accessed on March 18, 2010 at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/105/03/PDF/G0810503.pdf?OpenElement>

³⁹ Commission on Human Rights resolution 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, preamble and para. 6, last accessed on March 18, 2010 at:

Reproductive health rights and the reproductive health itself were comprehensively defined in 1994 at the International Conference on Population and Development Program of Action (ICPD) in Cairo.⁴⁰ This program recognized the “*freedom to decide if, when and how often to [reproduce]*”⁴¹ which is connected to the right to freely and responsibly decide on the number and timing of the children they want to have recognized (together with the right to have access to information, education, etc.) in the CEDAW convention.⁴² With respect to the exercise of the conscientious objection, sexual and reproductive rights and services are those most frequently affected.

The basic conditions laid on the health care services are that they must be available, of a good quality and accessible.⁴³ The availability and accessibility of the health care services mean basically that there must be a sufficient number of such services and the health care professionals who can offer them. They should also be financially available and available in appropriate time. Again, these conditions happen to be undermined by the exercise of contentious objection right, when the health care professional refuses to provide particular treatment or service and no other geographically, financially or timely accessible alternative providers are available. Such obstructions can then render ‘*de iure*’ legally available health care services unavailable ‘*de facto*’ and, for example, in cases of refusal of abortion consequently cause increase in the rates of illegal or unsafe abortions. No less important is the

http://search.ohchr.org/search?q=cache:WYbR-LE4zl0J:ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2003-28.doc+2003%2F28&ie=utf8&output=xml_no_dtd&client=en_frontend&proxystylesheet=en_frontend&site=default_collection&access=p&oe=UTF-8

⁴⁰ United Nations International Conference on Population and Development Program of Action, Cairo 1994 last accessed on March 10, 2010 at: <http://www.iisd.ca/cairo.html>

⁴¹ Programme of Action of the UN ICPD, A. Reproductive rights and reproductive health, Basis for action, point 7.2., last accessed on March 18, 2010 at: <http://www.iisd.ca/Cairo/program/p07002.html>

⁴² Convention on the Elimination of All Forms of Discrimination Against Women (1979), article 16(1e), last accessed on March 18, 2010 at: <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article16>

⁴³ J. B. de Mesquita and L. Finer, “*Conscientious objection: Protecting Sexual and Reproductive Rights*”, Human Rights Center, University of Essex, p.1-16, 10, last accessed on March 18, 2010 at: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Conscientious_objection_final.pdf

quality of the health care service. The service received by the patient must be of a high professional quality which should not be affected by personal moral, religious or ethical views of the provider.⁴⁴

In addition, the basic right to health not only includes the right of access to health care, but also the prohibition of discrimination⁴⁵ in this sphere. However, through the exercise of conscientious objection in health care this right not to be discriminated against can be violated. Discrimination can appear for example in case when the only health care professional in the area is the objecting one. In such a case it could happen that women from this area requesting particular reproductive health care service would not have access to it even if it is legally available in the country.

According to the General Recommendation 24 of CEDAW convention with respect to paragraph 11, “*It is discriminatory for a State party to refuse ... performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.*”⁴⁶ Nevertheless, if we consider that the conscientious objection in health care is most commonly used with respect to provision of reproductive services, women are those whose health can be adversely affected and who will be discriminated against when compared to men.

⁴⁴ J. B. de Mesquita and L. Finer, “*Conscientious objection: Protecting Sexual and Reproductive Rights*”, Human Rights Center, University of Essex, p.1-16, 10, last accessed on March 18, 2010 at:

http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Conscientious_objection_final.pdf

⁴⁵ International Covenant on Economic, Social and Cultural Rights, Office of the United Nations High Commissioner for Human Rights, Article 2(2), last accessed on March 18, 2010 at:

<http://www2.ohchr.org/english/law/cescr.htm>

⁴⁶ General Recommendation made by the Committee on the Elimination of Discrimination against Women, No. 24 on Women and Health, 1999, paragraph 11 with respect to Article 12(1), last accessed on March 14, 2010 at:

<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>

CHAPTER II

Regulation of conscientious objections in health care in the legal systems of the United States of America, the United Kingdom and the Slovak Republic

As described in Chapter I of this paper, conscientious rights are recognized in several international instruments as the “right to the freedom of conscience, though and religion”.⁴⁷ Nevertheless, certain limitations are recognized – such as protection of health, morals and the rights of others⁴⁸. Besides these international instruments, states themselves regulate conscientious clauses in their national legal systems. Thus, in this Chapter, I will introduce and analyze regulation of the conscientious objections with respect to reproductive health care services in the legal systems of the USA, UK and SR as they provide good example of how far the conscientious objection can go and what limitations there are. The aim is to show that even though there are some common features between all of them, there are also major differences especially in the scope of regulation, subjects entitled to claim such objection and their restriction. This will be reached through comparative perspective offered by each subsequent section analyzed, that will point out major differences between the regulation of the country to which the particular section is devoted and regulations of those already discussed.

⁴⁷ Article 18, The Universal Declaration of Human Rights, last accessed on March 18, 2010 at:
<http://www.un.org/en/documents/udhr/>

⁴⁸ Article 18(3), International Covenant on Civil and Political Rights, last accessed on March 18, 2010 at:
<http://www2.ohchr.org/english/law/ccpr.htm#art16>

2.1. The United States of America – Excessive protection of conscientious objectors at the expense of patients' right to access health care

The United States of America is a federation composed of 50 states. Federal, as well as the state laws provide for the possibility of health care providers to use conscientious objections as a ground for refusal of treatment and there is a great variety in their regulation. The differences consist especially in the subjects to whom they apply, extent to which they apply, including whether they only apply to the procedure itself, or even assistance, whether there is a duty of referral to another health care provider not objecting to the treatment or whether there are certain limitations placed upon these clauses.⁴⁹

The conscientious objection with respect to health care services was first introduced in the USA in the 1970's with the first Federal Act protecting health care providers' right to object on religious or moral grounds to perform abortion or sterilization procedures.⁵⁰ Since that time many states enacted their own conscientious clauses. For example, Arkansas enacted the conscientious clauses with respect to abortion, contraception and sterilization. In all three clauses it stipulated that individuals can not be forced to participate in abortion or sterilization procedures and even that hospitals can not be required to allow performance of such procedures on its premises. Moreover, neither the duty of the objector to notify the affected person nor the duty to provide the affected person with information on the legally available procedures or the referral to another health care provider or institution able to provide such service was stipulated. The

⁴⁹ As can be seen on the internet site of National Conference of State Legislatures:
<http://www.ncsl.org/IssuesResearch/Health/PharmacistConscienceClausesLawsandLegislation/tabid/14380/Default.aspx>

⁵⁰ 42 U.S.C. 300a-7(b), Public Health Service Act, enacted in 1970, last accessed on March 18, 2010 at:
http://www.law.cornell.edu/uscode/42/usc_sec_42_0000300---a007-.html

contraception refusal clause applied in the same way also to pharmacists or other paramedic personnel.⁵¹

While the right of people to act in conformity with their conscience is considered to be one of the fundamental human rights recognized by various international and national instruments, the protection of this right can sometimes go too far. To demonstrate this, I will use the example of newer Mississippi act on conscience, analyzed by Professor Emeritus of Health Law and Policy at the Faculty of Law, University of Toronto, Bernard M. Dickens⁵².

In 2004, **Mississippi** enacted a comprehensive act on conscience called the Mississippi Health Care Rights of Conscience Act⁵³. According to its Section 2(a), the objection can be used not only by those directly delivering the health care service, but also those who provide “*any other care or treatment rendered by health care providers or health care institutions*”.⁵⁴ Thus, the Act covers the refusal to provide health care service by a health care provider under the objection of conscience not only with respect to direct delivery of service or treatment but also all the additional services accompanying the delivery of the health care, such as for example prescribing the pills, instructing the patient, referral of

⁵¹ Ark. Code Ann. § 20-16-601, enacted in 1969, Ark. Code Ann. § 20-16-304, enacted in 1973, Ark. Code Ann. § 20-16-304, enacted in 1973

⁵² B.M. Dickens, “*Legal protection and limits of conscientious objection: When conscientious objection is unethical*”, *Med Law* (2009) 28: 337 – 347, available at:
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1483363

⁵³ Mississippi Health Care Rights of Conscience Act 2004, last access on March 13, 2010 at:
<http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm>

⁵⁴ Mississippi Health Care Rights of Conscience Act 2004, Section 2(a), last access on March 13, 2010 at:
<http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm>

the patient to another treatment or health care service provider who is able to deliver it not using the objection, instructing the patient on the diagnosis and prognosis, etc.⁵⁵

At the same time this Conscience Act specifies that health care providers are considered to be not only physicians, nurses, pharmacists, their assistants, researchers and others, but also all the other persons who deliver the health care or are assisting in delivery of the health care service⁵⁶. Thus it gives a broad possibility to use conscientious objection as a ground for refusal of treatment or health care service also to any procedure accompanying it and any persons involved in it.

Furthermore, this Act clarifies what is understood under the word ‘conscience’. ‘Conscience’ is understood here as “*religious, moral or ethical principle held by a health care provider, the health care institution or health care payer*”⁵⁷. When the health care provider refuses the delivery of treatment or participation towards delivery of such treatment on the basis of his conscience as stipulated in this Act, no liability proceedings can be launched against him. He is immune from any civil, criminal and administrative liability in such cases.⁵⁸ Moreover, any discrimination with respect to health care

⁵⁵ Ibid, section 2(a) stating: "Health care service" means any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counselling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions."

⁵⁶ Ibid, section 2(b) stipulating: ““Health care provider’ means any individual who may be asked to participate in any way in a health care service, including, but not limited to: a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counsellor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure.”

⁵⁷ Ibid, section 2(h)

⁵⁸ Ibid, section 3(2) stipulating: “No health care provider shall be civilly, criminally, or administratively liable for declining to participate in a health care service that violates his or her conscience. However, this

providers objecting towards delivery of the particular treatment according to this Act is also prohibited.⁵⁹

The laws such as this one, regulating use of the conscientious objection in such broad terms, in fact place patients or individuals in need of a medical treatment or service in a subordinate position and allow the religious, moral or ethical preferences of the health care providers to prevail over the needs of patients. Consequently, they can often result in an abuse of such objections based on personal preferences of the health care provider and thus adversely affect the patients' most precious value - health.

Thus, as B. M. Dickens described further in his Article, such broad regulation of the conscientious rights of the health care professionals could bring along really extreme situations, such as for example: nurses refusing to provide any, pre as well as post-operative care to patients that underwent abortions, physicians' refusal to inform a patient on their diagnosis, medical prognosis and the options for the treatment they choose to undertake in order, for example, to avoid the situation when the patient would go for the treatment which the physician considers to be from his personal religious, moral or

subsection does not exempt a health care provider from liability for refusing to participate in a health care service regarding a patient because of the patient's race, colour, national origin, ethnicity, sex, religion, creed or sexual orientation."

⁵⁹ Ibid, section 3(3) stipulating: "It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience. ... discrimination includes, but is not limited to: termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary or retaliatory action."

ethical perspective against his conscience.⁶⁰ As a result of such broad application of conscientious rights guaranteed not only to individual health care professionals but also institutions themselves, it is clear that the access to reproductive services, information on the possible medications, diagnosis, prognosis, etc. could in fact become impossible and thus patients' rights, and mainly health, would be placed at significant risk.

As the USA is composed of 50 states, the majority of which enacted certain conscientious objection clauses or separate comprehensive conscientious laws⁶¹, utilization of the conscientious objections in health care services is not rare. However, when hearing about the refusals of the health care services, people usually associate these refusals based on conscience with the physicians or nurses not providing the treatment to the patient. Notwithstanding such initial deductions especially in the United States several cases appeared when these objections were being claimed by pharmacists.⁶² Their objections generally relate to filling legal prescription for emergency contraception known as the 'morning-after-pill' or storing such a pill. Probably one of the first cases that set off the campaign regarding the pharmacists' right to conscientious objection was the issue publicized in the media in 2004, when pharmacists in Devon refused to provide the

⁶⁰ B. M. Dickens, "Legal protection and limits of conscientious objection: When conscientious objection is unethical", *Med Law* (2009) 28: 337 – 347, available at:

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1483363, last accessed on 16 March, 2010

⁶¹ As can be seen on the internet site of National Conference of State Legislatures:

<http://www.ncsl.org/IssuesResearch/Health/PharmacistConscienceClausesLawsandLegislation/tabid/14380/Default.aspx>

⁶² M. Davy, P. Belluck. "Pharmacies Balk on After-Sex Pill and Widen Fight in Many States", New Your Times, April 19, 2005 last accessed on March 20, 2010 at:

http://www.nytimes.com/2005/04/19/national/19pill.html?pagewanted=1&_r=1

emergency contraception to a rape victim and were consequently fired for doing so.⁶³

Furthermore, some cases were noticed when pharmacists not only refused to fill a prescription but also to refer the patient to another pharmacy or pharmacist who would be willing to provide the pills or even cases when a pharmacist refused to return such a prescription to the patient.⁶⁴ Thus, a big campaign for the pharmacist use of religious or moral objections began even though the states' views on this matter differ. Some introduced proposals that compel pharmacists to fill prescriptionsy prescribed⁶⁵, others allowing pharmacists to refuse to dispense these pills on the basis of their contentious objections⁶⁶.

The issue of conscientious objections with respect to refusal of medical treatment or provision of health care services is still a very hot topic, which was demonstrated also recently, just before the end of the president's George Bush administration. Shortly before the end of his administration, the Department of Health and Human Services introduced new federal regulation for the protection of conscience.⁶⁷

⁶³ T. Zwillich, "US Pharmacies vow to withhold emergency contraception", *The Lancet*, Volume 365, Issue 9472, p1677-1678, May 14, 2005, lastly accessed on March 14, 2010 at:

[http://thelancet.it/journals/lancet/article/PIIS0140-6736\(05\)66531-2/fulltext](http://thelancet.it/journals/lancet/article/PIIS0140-6736(05)66531-2/fulltext)

⁶⁴ A. Grady, "Legal Protection for Conscientious Objection by Health Professional", *Virtual Mentor, Ethics Journal of the American Medical Association*, May 2006, Volume 8, Number 5: 327-331, p.327 Michigan Example - when married woman with children visited pharmacy to get the pill and pharmacy withheld the prescription, last accessed on March 15, 2010 at: <http://virtualmentor.ama-assn.org/2006/05/hlaw1-0605.html>

⁶⁵ Such as for example: California, Missouri and New Jersey and Michigan to be seen at:
<http://www.ncsl.org/IssuesResearch/Health/PharmacistConscienceClausesLawsandLegislation/tabcid/14380/Default.aspx>, last accessed on March 20, 2010

⁶⁶ Such as for example: Arkansas, South Dakota, Mississippi and Georgia, to be seen at:
<http://www.ncsl.org/IssuesResearch/Health/PharmacistConscienceClausesLawsandLegislation/tabcid/14380/Default.aspx>, last accessed on March 20, 2010

⁶⁷ Regulation 45 CFR Part 88, U.S. Department of Health and Human Services, Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, enacted 2008, to be seen at: <http://www.consciencelaws.org/Conscience-Laws-USA/Conscience-Laws-USA-07.html>

This regulation was very much criticized for giving health care professionals objecting to the legally available health care services or treatments too much ‘power’, resulting in the abandonment of the patients and placing the interests of the health care providers above the interest of the patients.⁶⁸ The reason for this criticism was that it not only includes protection of the health care personnel with respect to direct delivery of the treatment or reproductive health care service (such as abortion procedure, contraception, voluntary sterilization) but also other types of participating in the provision of these legally obtainable services.⁶⁹

Even though its primary aim was supposed to be the protection of health care providers against discrimination, in practice it seems more likely that with this regulation the reproductive services would become ‘*de facto*’ unavailable. One of the most important deficiencies of this regulation is considered to be the ignorance of the special professional responsibility which the health care personnel bear towards the patients.⁷⁰ This responsibility they gain immediately after joining their professions and so it is necessary to mention that patients’ physical and psychical well-being is supposed to be the primary goal of their job. Patients are in a vulnerable position when compared to health care providers and are dependant on health care providers’ professional knowledge which, however, should not be prejudiced by their personal judgments and preferences. The fact

⁶⁸ J.D. Cantor, “*Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine*”, The New England Journal of Medicine, Volume: 360, April 9, 2009, p. 1484-1485, 1485, available at: <http://nejm.highwire.org/cgi/content/short/360/15/1484?query=prearrow>, last accessed March 18, 2010

⁶⁹ Regulation 45 CFR Part 88, U.S. Department of Health and Human Services, Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, § 88.2 , to be seen at: <http://www.consciencelaws.org/Conscience-Laws-USA/Conscience-Laws-USA-07.html>

⁷⁰ B. M. Dickens, “*Unethical Protection of Conscience: Defending the Powerful against the Weak*”, Virtual Mentor, September 2009, Volume 11, Number 9: 725-729, available at: <http://virtualmentor.ama-assn.org/2009/09/oped2-0909.html>, last accessed March 18, 2010

that this regulation protects and allows health care personnel to withhold the information from the patient, places the health care providers and patients in an unequal position where the only possibility of the patients is to trust the professionals and believe in their integrity as they are dependant on them as concerns the treatment.⁷¹

As mentioned earlier, after this regulation was introduced, the wave of criticism rose. One of the opponents was the Connecticut Congressman, Chris Murphy, who introduced the Protecting Patient and Health Care Act of 2009,⁷² whose aim was to oppose this new federal regulation.⁷³ This federal regulation was also opposed by the California Assembly woman Mrs. Mary Hayashi, who introduced the Assembly Bill 120 aiming to ensure that women in California can get information regarding the reproductive choices they can make. This proposal also stipulated that failure to comply with this duty resulted in professional misconduct and is to be followed by disciplinary proceedings⁷⁴.

Furthermore, to oppose the federal regulation, three lawsuits were filed in the U.S. Connecticut District Court. One of them represented seven states, namely Connecticut, Rhode Island, Oregon, New Jersey, California, Illinois and Massachusetts and was filed by the Attorney General, other two were filed on behalf of National Family Planning &

⁷¹ B. M. Dickens, “*Unethical Protection of Conscience: Defending the Powerful against the Weak*”, *Virtual Mentor*, September 2009, Volume 11, Number 9: 725-729, available at: <http://virtualmentor.ama-assn.org/2009/09/oped2-0909.html>, last accessed March 18, 2010

⁷² HR 570: Protecting Patients and Health Care Act, introduced in 2009, To make certain regulations have no force or effect, to be seen at: <http://www.govtrack.us/congress/bill.xpd?bill=h111-570>, last accessed on March 18, 2010

⁷³ ‘Murphy pushes legislation to stop Bush’s “Refusal Clause” Limiting Access to Health Care’, January 15, 2009, to be seen at:

http://www.chrismurphy.house.gov/index.php?option=com_content&task=view&id=260&Itemid=55, last accessed on 23 March, 2010

⁷⁴ ‘*Hayashi legislation in response to controversial medical “conscience rule”*’, California Chronicle, January 15, 2009, last accessed on March 19, 2010 at:

<http://www.californiachronicle.com/articles/view/87999>

Reproductive Health Association by the American Civil Liberties Association and by the Planned Parenthood Federation of America.⁷⁵

Even though the new administration of president Obama presented the aim to revoke this federal regulation, later on it was proclaimed that the federal conscientious clauses will remain in force and that the way of ‘sensible’ conscientious clauses should be used to meet the balance between the patients’ rights to access health care and health care professionals’ conscience.⁷⁶

To conclude this section, it is very difficult to describe the approach of the USA to contentious objections. The reason is the heterogeneity in regulation. with respect to subjects Nevertheless, I suppose that on the basis of the above analysis, it is not overbold to say that some of these regulations, such as the Mississippi one are extremely broad with respect to who can use them and scope in which these objections can be exercised. They place the will and personal conviction of the health care professional above the patient’s interest and that present a danger to the effectiveness of the access to health care services.

In the field of health care it is difficult, if not impossible, to form an ‘equal’ relationship between the health care professional and the patient. The patient is generally always the

⁷⁵ Rob Stein The Washington Post, “Lawsuits filed over Rule that Lets Health Workers Deny Care”, January 16, 2009, last accessed on March 14, 2010 at:
<http://www.washingtonpost.com/wpdyn/content/article/2009/01/15/AR2009011502059.html?hpid=moreheadlines>

⁷⁶ The White House Office of the Press Secretary, Remarks by the President in Commencement address at the University of Notre Dame, South Bend, Indiana, May 17, 2009, last accessed on March 20, 2010 at:
http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Notre-Dame-Commencement/

one without sufficient medical knowledge and education and thus is more vulnerable in this relationship. Thus, this unequal relationship should be balanced through the patients' rights that include not only the provision of health care without any discrimination but also informing the patient about the status of his health, diagnosis, prognosis, or the legally available options for his further treatment as it will be shown to be recognized in the United Kingdom in next section. Yet, this balance is undermined when the laws on conscientious objections are too broad. Because of this, if such laws exist they should be sufficiently limited in order to reach the balance between the health care professional's right to object on the basis of their conscience and the patient's right.

2.2. The United Kingdom – Way to a fine balance between the conscientious objectors' rights and rights of patients

The United Kingdom is a country that also enacted in its legislation clauses on conscientious objection. However, unlike the above analyzed Mississippi in the USA whose right to rely on the contentious objection is almost unlimited, the UK offers limitation on the use of these objections.

Compare to the US Mississippi, the United Kingdom's legislation on conscientious objection in the field of health care seems to provide a fine limitation on the use of such objection.⁷⁷ Its Abortion Act 1967⁷⁸ includes the provision on conscientious objection, but at the same time, it lays certain limitations on it. Section 4(1) of this Act stipulates:

⁷⁷ Note that neither the Abortion Act 1967 nor the Human Fertilisation Act 1990 apply to Northern Ireland

⁷⁸ Abortion Act 1967, section 4, last accessed on March 20, 2010 at:

<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

*“no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection”*⁷⁹ Thus, the right is preserved, however, the latter provision in section 4(2) of this act puts limitation upon it by stipulating that: “*Nothing in subsection (1) of this section shall effect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman*”.⁸⁰ Thus, when the life or health of woman is at stake, persons can not rely on the conscientious objection provision and refuse to provide the treatment.

By contrast to the Mississippi regulation on contentious objection where the participation in the health care service was interpreted broadly, including not only the direct treatment itself but also the referral of patient, counseling, information on prognosis and diagnosis, etc.,⁸¹ in the UK the right not to participate in the abortion procedures was interpreted narrowly. For example, it was made clear by the courts that typing a referral letter for abortion can not be considered as meaning ‘to participate’ in the procedure. Thus, the secretary typing such a letter can not refuse to do so by relying on the objection based on her conscience as stipulated by the Abortion Act.

This was recognized by the court in the case of *Barbara Janaway*⁸² - a secretary in the hospital - who refused to type a letter referring a patient to a different health care

⁷⁹ Abortion Act 1967, section 4(1) last accessed on March 20, 2010 at:
<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

⁸⁰ Abortion Act 1967, section 4(2), last accessed on March 20, 2010 at:
<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

⁸¹ Mississippi Health Care Rights of Conscience Act 2004, Section 2(a), last accessed on March 13, 2010 at: <http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm>

⁸² *Janaway v. Salford Health Authority*, [1989] A. C. 537 (House of Lords)

authority for abortion. As a result of this, her action was identified as professional misconduct and her job contract was terminated. Consequently, she sought judicial review for wrongful termination of her employment and claimed conscientious objection. However, the Court upheld the decision of her former employer and stated that her refusal to type the referral letter on the basis of her conscience was not justified because this objection legally recognized in the Abortion Act does not include action of such indirect relevance.⁸³ Equally, it was recognized that the referral of a patient by the objecting doctor to the one that is willing to deliver the treatment can not be considered as ‘participation’ in the procedure, thus the objecting doctor has a duty to refer the patient and can not rely on conscientious objection towards such referral.⁸⁴

Besides the Abortion Act 1967, the conscientious clause is also regulated in the *Human Fertilisation and Embryology Act 1990*.⁸⁵ Section 38(1) stipulates: “*No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so.*”⁸⁶ However, compared to the Abortion Act, the Human Fertilisation and Embryology Act does not state in further sections any limitations on the use of objection.

In addition, the General Medical Council (hereafter referred to as “GMC”) was established in the United Kingdom with one of its duties being to provide doctors with

⁸³ *Janaway v. Salford Health Authority*, [1989] A. C. 537 (House of Lords), p.570 C-G

⁸⁴ *Barr v. Matthews* [2000], 52 B.M.L.R. 217 (Queen’s Bench Division)

⁸⁵ Human Fertilisation and Embryology Act 1990 Chapter 37, para. 38, last accessed on March 20, 2010 at: http://www.opsi.gov.uk/Acts/acts1990/ukpga_19900037_en_3#pb12-11g38

⁸⁶ Human Fertilisation and Embryology Act 1990, Chapter 37, section 38(1), last accessed on March 20, 2010 at: http://www.opsi.gov.uk/Acts/acts1990/ukpga_19900037_en_3#pb12-11g38

guidance on medical ethics.⁸⁷ In 2006, this Council issued the guidance on the Good Medical Practice.⁸⁸ On the basis of this guidance, a doctor can not be prejudiced in the provision of health care services to which he bears professional responsibility because of his personal perception or view of a patient's lifestyle or belief that may oppose the doctor's personal perception or belief.⁸⁹ Such an approach would be discriminatory and there is no place for it in the modern medical care respecting patients' rights. However, in cases when the doctor's personal perception could have an affect on medical treatment, the doctor has a duty to inform a patient about it and about his right to see another doctor. Otherwise, the GMC can start disciplinary proceedings against him for professional misconduct.⁹⁰

GMC issued also the supplementary ethical guidance for doctors on Personal beliefs and medical practice⁹¹. Compare to the Mississippi act on conscience, which protected health care providers even from duties to inform and refer the patient,⁹² this guidance made it clear that doctor has to inform a patient about the procedure of treatment which patient can legally undertake even if this doctor himself objects towards the particular treatment. Moreover, it stipulated that despite of personal beliefs of perceptions the doctor must

⁸⁷ General Medical Council was established under the Medical Act 1858, to be seen at:
<http://www.statutelaw.gov.uk/content.aspx?activeTextDocId=1042982>

⁸⁸ Good Medical Practice of the General Medical Council (2006), last accessed on March 20, 2010 at:
http://www.gmc-uk.org/guidance/good_medical_practice.asp

⁸⁹ Good Medical Practice: Decisions about access to medical care, para. 7, last accessed on March 20, 2010 at: http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_decisions_about_access.asp

⁹⁰ Good Medical Practice: Decisions about access to medical care, para. 8, last accessed on March 20, 2010 at: http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_decisions_about_access.asp

⁹¹ Personal beliefs and medical practice – guidance for doctors of the General Medical Council 2008, last accessed on March 20, 2010 at: http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp

⁹² Mississippi Health Care Rights of Conscience Act 2004, Section 2(a), last access on March 13, 2010 at: <http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm> for details see footnote 53

behave to patient with respect and that any kind of discriminatory objection is prohibited.⁹³

The professional body of pharmacists in the UK is the Royal Pharmaceutical Society⁹⁴.

As Lynsey Balmer described in her article⁹⁵, the pharmacists have their own Code of Ethics⁹⁶ which places on them a duty to act in the best interest of the patient. It recognizes pharmacists' objections, too, especially objection to dispense the emergency contraception, however it stipulates that in such cases patient's beliefs must be respected as well and patients must be informed on where they can get requested service.⁹⁷ Moreover, she reiterates in the article that pharmacist who bears contentious objection towards certain services he should normally provide as a part of his professional duties, has a duty to inform the employer about this fact before accepting the job. In such a way, the pharmacy can undertake all the necessary steps to guarantee patients' entitlement to the access of health care services which pharmacy provide.⁹⁸ The newest case of

⁹³ Personal beliefs and medical practice, Doctors' personal belief, para. 20-25, last accessed on March 20, 2010 at: http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp#5

⁹⁴ Royal Pharmaceutical Society of Great Britain is professional and regulatory body of English, Scottish and Welch pharmacists, to be seen at: <http://www.rpsgb.org.uk/>

⁹⁵ L. Balmer, "Royal Pharmaceutical Society and conscientious objectors", *The Lancet*, Volume 367, Issue 9527, p1980, 17 June 2006, last access on March 15, 2010 at:

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68884-3/fulltext?eventId=login](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68884-3/fulltext?eventId=login)

⁹⁶ Code of Ethics for Pharmacists and Pharmacy Technicians, last accessed on March 20, 2010 at: <http://www.rpsgb.org/pdfs/coept.pdf>

⁹⁷ Code of Ethics for Pharmacists and Pharmacy Technicians, Section 3(4), last accessed on March 20, 2010 at: <http://www.rpsgb.org/pdfs/coept.pdf>

⁹⁸ L. Balmer, "Royal Pharmaceutical Society and conscientious objectors", *The Lancet*, Volume 367, Issue 9527, p1980, 17 June 2006, last access on March 15, 2010 at:
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68884-3/fulltext?eventId=login](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68884-3/fulltext?eventId=login)

pharmacist who refused to give patient – Mrs. Deeley – legally prescribed contraceptive pills on the basis of religious belief occurred in media just recently, on March 10, 2010.⁹⁹

Regardless of what category of Health care professionals can invoke conscience, all of these professionals should be aware of their professional duties towards patients. These duties should be of utmost importance for them and prevail over their personal beliefs. They should give up certain portion of their autonomy for the benefit of patients. As argued in the article written by Charles Williams: “*A legitimate claim for conscientious objection should be based on a deeply held objection to what the patient is asking the doctor to do, not what the patient has done or how the patient lives*”.¹⁰⁰

The General Medical Council recognizes the importance of the moral and religious values for patients as well as doctors . It mentions the central principle of the Good Medical Practice¹⁰¹ - the respect for human life and principle of nondiscrimination of patients. Moreover, it upholds the right to conscientious objection by reiterating that if there is a treatment or health care service to which the doctor objects, he should inform the patient in this regards and refer him to another health care professional.¹⁰²

⁹⁹ C. Brooke, ‘*Pharmacist refuses to give mother, 38, contraceptive pills for period pain “because of her religion”*’, *MailOnline*, 10th March 2010, to be seen at: <http://www.dailymail.co.uk/news/article-1256602/Pharmacist-refuses-mother-38-contraceptive-pills-religion.html>

¹⁰⁰ C. Williams, “*Contentious objection*”, discussion of doctors’ right to stand by their moral convictions, *Student BMJ*, Volume 16, July 2008, 264 – 265, to be found at: <http://archive.student.bmj.com/issues/08/07/life/264.php>

¹⁰¹ Good Medical Practice: Duties of a Doctor (2006) of the General Medical Council, to be seen at: http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp accessed on March 16, 2010

¹⁰² Good Medical Practice: Decisions about access to medical care, para. 8, lastly accessed on March 20, 2010 at: http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_decisions_about_access.asp

UK's regulation of the conscientious objection in health care either in the legislative acts or in the carefully developed guidance allows the contentious objectors to act in conformity with their conscience but at the same time this right is not unlimited. On the contrary, it is to be balanced by the patient's right. Both, the Abortion Act 1967 as well as the GMO guidance on Good Medical Practice and supplementary guidance make it clear that limitation is necessary. The first aim that must be observed, but not the last one, is the duty of the doctors to act in the best interest of the patient.¹⁰³ Thus, even though the cases of abuse of the conscientious objection may appear in practice from time to time, at least these rules attempt to reach the balance between health care professional's right and patients' rights to access to legally available reproductive health care services. Unlike the USA, the UK provides for certain balance between those 'competing' interests.

2.3. The Slovak Republic – The lack of specific regulation of conscientious objection as a precondition for future controversies

In the Slovak Republic, the general right to the freedom of conscience and thought is recognized as one of the fundamental human rights and is addressed in article 15(1) of the *Charter of Fundamental Rights and Basic Freedoms of the Slovak Republic*¹⁰⁴. Further, it is regulated also in article 24 (1) of the *Constitution of the Slovak Republic*¹⁰⁵. However, at the same time, Article 24(4) of the Constitution of the Slovak Republic limits the existing right by reiterating that these rights "can be legally restricted only as a

¹⁰³ Good Medical Practice: Duties of a doctor, lastly accessed on March 20, 2010 at:
http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

¹⁰⁴ Charter of Fundamental Rights and Basic Freedoms of the Slovak Republic introduced by the constitutional act No 23/1991 Coll, Article 15, para. 1 to be seen at:

http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm

¹⁰⁵ Constitution of the Slovak Republic (Act No. 460/1992 Coll. Of September 1st, 1992), to be seen at:
<http://www-8.vlada.gov.sk/index.php?ID=1376>

measure taken in a democratic society for the protection of the public order, health, morality, and rights and freedoms of other people”¹⁰⁶.

Regarding the area of the heath care, Slovak Republic introduced general provision on the conscientious objection that allows health workers to refuse to perform any treatment in conflict with their conscience. Conscientious objection is regulated in the appendix No 4 to the Act on the healthcare providers, health workers and professional organisations in the health service under the heading ‘Code of Ethics of Health worker’.¹⁰⁷ According to the provision on the conscientious objection in this Code, “*the health worker cannot be required to provide such treatment or participation in treatment that contradicts with his conscience except in situations when there is a risk of immediate threat to life or health of the people.*”¹⁰⁸ Thus, similarly to the UK’s conscientious objection clause in the Abortion Act 1967¹⁰⁹, it provides limitation on the invocation of conscientious clause when life or health is threatened. The same provision further stipulates: “*If the health worker uses the conscientious objection, he/she has a duty to inform about this fact his employer and patients*”¹¹⁰ and so it creates the basic duty to inform a patient about the objection.

¹⁰⁶ Ibid, Article 24(4)

¹⁰⁷ Act No. 578/2004Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, to be seen at: http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm, last accessed on March, 17, 2010

¹⁰⁸ Ibid, Appendix 4 - Code of Ethics of the Medical worker, clause 3

¹⁰⁹ Abortion Act 1967, Section 4(2), last accessed on March 20, 2010 at:
<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

¹¹⁰ Ibid, Appendix 4 - Code of Ethics of the Medical worker, clause 3

The Slovak Republic is a typical post-communist country. Maybe because of that the organizations which would publicly support the women' reproductive rights are rare.¹¹¹

Even though the influence of the Catholic Church is not as strong as for example in Poland, still a majority of Slovak population - 73% - report to be Catholics.¹¹² Thus, the vast majority of the contentious objections in the provision of health care arise when it concerns the religiously very much criticized matters such as abortion procedures. Abortions are legally available in the Slovak Republic not just on the basis of health indication such as for example the risk to the health or life of woman or the defect of the fetus but also on the basis of request by the woman, of course within specified time limit of pregnancy.¹¹³

However, it is impossible to report the exact number or frequency with which the contentious objections are exercised by health workers with respect to reproductive services in the Slovak Republic. There can be several reasons for this. Either it is not exercised very often, or once it is used individuals affected by this objection take it as 'normal' and maybe because of the totalitarian past still consider a doctor to be the 'authority' in patient – doctor relationship and thus do not report it and basically just approach another doctor who is willing to perform the procedure. Still, a few cases can be found that appeared in the media with respect to exercise of contentious objection when

¹¹¹ Association for Parenthood Planning and Education on Parenthood was established in 1991 and deals with reproductive health and respect of fundamental reproductive rights of people, available on : <http://rodicovstvo.wordpress.com/antikoncepcia/historia/>

¹¹² Statistics used from the Official website of the Catholic Church in Slovakia, to be seen at; <http://www.kbs.sk/?cid=1184747346>

¹¹³ Act No. 73/1976 Coll., Abortion Act, Article 4, time limit was set to 12 weeks when abortion performed without medical indication upon the request of a woman, last accessed on March 20, 2010 at: http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm

the abortion was refused by the doctor, however, till now none of them were subject to court decision on this matter.¹¹⁴

While in the USA as mentioned in section 2.2 of this paper, conscientious objection can be raised by the institution itself as well, according to Slovak legislation, only the health workers can invoke it.¹¹⁵ The legislative provision specifies that “*health care worker is a natural person*”¹¹⁶ and so in no way the institution itself can rely on the clause about the refusal of treatment or participation in controversial treatment as stipulated in the Code of Ethics. Despite this, in practice there have been examples when the performance of the abortion procedures was prohibited in the whole hospital or where the abortions were performed only when there was health indicated reason on the site of the woman.¹¹⁷

This happened, for example, in one particular hospital in the average size Slovak town of Čadca, where the director prohibited the performance of abortions requested by women without any health indication in the whole hospital, even though such a procedure is legal in the country. When the director of the hospital was interviewed on this issue, he stated that such a decision was within his competence and that he was “*just trying to protect*

¹¹⁴ “Lekár v Prešove odmietol podať pacientke liek na potrat, prepustili ho“ (Physician in Presov refused to give a patient drug for abortion and was dismissed), SME, 2.3.2005, last accessed on March 9, 2010 at: <http://www.sme.sk/c/1953484/lekar-v-presove-odmietol-podať-pacientke-liek-na-potrat-prepustili-ho.html>

¹¹⁵ Act No. 578/2004Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Annex 4 – Code of Ethics of Health Worker, lastly accessed on March 10, 2010 at: http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm, last accessed on March, 17, 2010

¹¹⁶ Act No. 578/2004Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Article 27, lastly accessed on March 10, 2010 at:

http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm, last accessed on March, 17, 2010

¹¹⁷ “Prerušenie tehotenstva – kde ano, kde nie”, (Abortion – where yes, where no), Moment, Volume 8, 2001, to be seen at: <http://moment.ref.megaloman.sk/2001-08/index01-s.html>

lives”¹¹⁸. Furthermore, the doctor employed in this hospital also responded that the prohibition laid on the abortion procedures with no health indication by the director is not the matter of individual doctors’ conscience and that the director’s regulation allows them to perform the abortion only after receiving his consent.¹¹⁹

This example clearly illustrates the abuse of the director’s position and the situation when the particular individual places his perception of conscience and what is morally good or wrong upon other people’s perception not necessarily sharing the same opinion. And neither the state bodies nor the courts did anything about it. Again, the reason might be that no one really complained about such a practice and instead patients visited the nearest hospital that performed the requested procedure.

However, despite the fact that the cases which appeared in media till now concerned only the doctors’ objections, it does not mean or indicate that other subjects can not invoke it like they can in the UK or in the USA. The Act on the healthcare providers, health workers and professional organisations in the health service identifies who is the health worker in Article 27 by stating that: “*Health worker is a natural person performing health profession*”¹²⁰ and further in this paragraph it specifies which health professions. Here, not only doctors – physicians are defined as health care professionals, but also for

¹¹⁸ MUDr. Jozef Valko, Director of the Čadca hospital for magazine Moment, „*Abortion – where yes, where no*“, Volume 8, 2001, last accessed on March 17, 2010 at: <http://moment.ref.megaloman.sk/2001-08/index01-s.html>

¹¹⁹ MUDr. Pavol Hartel, Head of the Gynaecological and Obstetric Department in Čadca Hospital for magazine Moment, „*Abortion – where yes, where no*“, Volume 8, 2001, last accessed on March 17, 2010 at: <http://moment.ref.megaloman.sk/2001-08/index01-s.html>

¹²⁰ Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Article 27, lastly accessed on March 10, 2010 at: http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm, last accessed on March, 17, 2010

example the dentist, nurse, pharmacist, physiotherapist, nutrition assistant, masseur, ambulance-man, etc.¹²¹

Thus, the scope of individuals who could refuse to provide the treatment or the participation in the treatment that conflicts with their conscience is broad and it is just a question of time when first cases, for example, of pharmacists refusing to fill the prescription and give the patient the contraceptive pills or even the masseur employed in the hospital refusing to provide massage to a woman who underwent abortion invoking his conscience, will appear in the media.

Moreover, unlike the US Mississippi having a provision expressing that the refusal of health care on the basis of conscience covers also the refusal to refer a patient to another health care provider¹²², there is no similar provision in the Slovak Republic. But at the same time there is nothing in Slovak legislation neither in the health care laws, nor in the Code of Ethics, which would oblige the health care worker objecting to the treatment or procedure on the basis of his conscience to refer the patient to the alternative health care provider or professional. Thus, it is clear that such a ‘hole’ in the regulation can cause significant controversies in the future.

Regarding the conscientious objections there was one significant event in the Slovak Republic. This was the signature of the Basic Treaty between the Holy See and the

¹²¹ Ibid, Article 27

¹²² Mississippi Health Care Rights of Conscience Act 2004, Section 2(a), last access on March 13, 2010 at: <http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm> for details see footnote 53

Slovak Republic¹²³ in 2001 which contains the general provision on the conscientious objection based on the religious beliefs. It states that: “*The Slovak Republic recognizes the right of all to obey their conscience according to the doctrinal principles and morals of the Catholic Church. The extent and conditions of the application of this right will be defined by special Accord between the [Holy See and the Slovak Republic]*”.¹²⁴ The special accord to which it refers was supposed to be separate treaty between the above mentioned contracting parties. However, even though there had been long lasting discussions on this Draft Treaty between the Slovak Republic and the Holy See on the Right to Objection of Conscience¹²⁵ that aimed to specify the extent and conditions on the application of the right to the contentious objection, the Draft treaty was accompanied with lots of criticism which consequently lead to its rejection.

As described in one of the analysis made with respect to this Draft treaty, there were several strong deficiencies.¹²⁶ First of all, it regulated the right to use the conscientious objection only on the ground of religious beliefs¹²⁷ and despite the fact that the religious rights and freedoms are fundamental, if conscientious objection is to be regulated, it should cover also those people with no religious affiliation to conscientiously object.

¹²³ Basic Treaty between the Holy See and the Slovak Republic No. 326/2001 Coll. to be seen at:
<http://www.culture.gov.sk/cirkev-nabozenske-spolochnosti/legislatva/zkony/zakladna-zmluva-medzi-slovenskou-republikou-a-svatou-stolicou>

¹²⁴ Basic Treaty between the Holy See and the Slovak Republic, Article 7, to be seen at:
<http://www.consciencelaws.org/Proposed-Conscience-Laws/International/Intl01.html>

¹²⁵ Draft Treaty between the Slovak Republic and the Holy See on the Right to Objection of Conscience:
<http://www.consciencelaws.org/Proposed-Conscience-Laws/International/Intl01.html>

¹²⁶ Analysis of the Draft Treaty between the Slovak Republic and the Holy See on the Right to Objection of Conscience available at:
<http://www.voltaire.netkosice.sk/archive/nabozensstvo/Analyza%20Zmluvy%20o%20vyhrade%20svedomia%20medzi%20SR%20a%20Svatou%20stolicou.doc>

¹²⁷ Article 3 of the Draft Treaty between the Slovak Republic and the Holy See on the Right to Objection of Conscience, available at: <http://www.consciencelaws.org/Proposed-Conscience-Laws/International/Intl01.html>

Secondly, the contentious objection was defined in the draft treaty as the objection based on the freedom of conscience, according to which everybody could refuse to perform things contradicting with his conscience.¹²⁸ The draft treaty demonstratively describes the areas to which the objection could apply¹²⁹, however, as it is not the exhaustive list of areas it could apply to any situation thus causing even the situations when the teachers would refuse to the refusal of paying taxes on the basis that they are used by the state to support the sexual education or treatments regarding the reproductive rights and similar.

Thirdly, another point of criticism expressed by this analysis was the situation which the provision of this draft treaty could create. According to the draft, not just Catholics but also all other persons can use conscientious objection however such objection can be based only on the principles of the Catholic Church.¹³⁰ Thus, it could happen that the courts interpreting this provision in the future would come to the conclusion that only the persons who are members of the Catholic church could use the objection and then when another person uses objection referring to this treaty, his objection could be ‘labeled’ as unfounded or abuse.

Fourthly, as was mentioned above, in the legal order of the Slovak Republic, no compact legal regulations exist with respect to contentious objection. In the area of health care conscientious objection is embodied in Annex 4 to the Act on healthcare providers, health workers and professional organisations in the health services according to which

¹²⁸ Ibid, Article 2

¹²⁹ Ibid, Article 4

¹³⁰ Ibid, Article 3(4)

limitations are in place when there is a threat to life or health.¹³¹ Once it would be ratified in the form of International Human Rights Treaty, in the legal order of the Slovak Republic it would have priority before the Acts of Parliament¹³². Consequently, this Draft Treaty never found its way through to be enacted in the Slovak Republic leaving the matters of conscience to be regulated just in a general form.

Thus, the Slovak Republic is another example of the countries that regulate conscientious objection in the area of health care. However, this regulation is not detailed but on the contrary very general and vague. It is not causing significant problems in present health care but it can be expected that, sooner or later, with the growing awareness of people of reproductive services available, and thereof their reproductive rights, the pressure of various religious groups in the country will multiply and the issue of who and to what extent exactly can conscientiously object as well as issue of referral of affected patients to another doctor or health care provider will have to be resolved.

¹³¹ Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Appendix 4 - Code of Ethics of the Medical worker, clause 3 to be seen at:

http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm

¹³² Constitution of the Slovak Republic (Act No. 460/1992 Coll. Of September 1st, 1992), Article 11, available at: <http://www-8.vlada.gov.sk/index.php?ID=1376> stating: "International instruments on human rights and freedoms ratified by the Slovak Republic and promulgated under statutory requirements shall take precedence over national laws provided that the international treaties and agreements guarantee greater constitutional rights and freedoms."

CHAPTER III

Acceptability, limitation and the best model of regulation of conscientious objection

The issue of acceptability of conscientious objection in the sphere of health care is very controversial. The question of whether it should or should not be allowed causes numerous contradictory opinions. Some of them call attention to the fact that conscientious objection does not have a place in the exercise of the profession. Others, however, claim that it is appropriate for health care professionals to rely on such objection. Opinions vary and thus also the regulation of the conscientious objection as can be seen in the analysis in Chapter 2. The aim of this chapter is to introduce various opinions with respect to the acceptability of conscientious objection and offer a model presenting the most appropriate regulation of the conscientious objection that provides the best balance between the conflicting rights of the health care Professional and the affected person.

3.1. Acceptability of conscientious objection and variety of opinions

The views on the acceptability of conscientious objection in the field of health care vary. Some of them claim that these objections have their place in health care, others that there is no place for them. According to the renowned medical ethicist, Julian Savulescu, the use of conscientious objections in health care should be illegal because doctors bear a

strong professional duty towards patients.¹³³ First, he argues that it is the law that stipulates what treatment or procedures are to be legally provided to patients, not the doctors' conscience. Secondly, he stipulates that doctors refusing a particular legally available treatment because it contradicts their conscience should not choose this profession as patients should be able to get all legally available treatments or procedures. Thirdly, he reiterates that: “... *[V]alues and conscience have different roles in public and private life. ... [T]hey should not influence the care an individual doctor offers to his or her patient. The door to “value-driven-medicine” is a door to a Pandora’s box of idiosyncratic, bigoted, discriminatory medicine. Public servants must act in the public interest, not their own.*”¹³⁴ Fourthly, he emphasizes that service actually becomes unavailable when conscientious objections are used in health care practice and thus also the system of health care becomes inefficient and not equitable. The reason is that it can be difficult for patients to find between the doctors those non-objecting ones who would be willing to provide requested treatment or procedure. Fifthly, Savulescu further reiterates that if doctors refuse even to refer a patient to another professional, this can cause delays in delivery of health care service to which the patient is entitled. Thus, it could also happen that patients lacking the knowledge about their rights will not receive treatment to which they are legally entitled. Sixthly, as he mentions even though the conscientious objection is considered to be based on the religious, moral or ethical reasons, the common reason for invoking the objection is religious belief. This creates significant inconsistency because on the one hand religion is accepted as the ground for invoking the objection but other grounds such as personal self-preservation when for

¹³³ J. Savulescu, “Conscientious objection in medicine”, *BMJ* 2006, 332, 294-297, last accessed on March 16, 2010 at: <http://www.bmjjournals.com/cgi/content/full/332/7536/294?ijkey=6NtRebQvp8GVGYn&keytype=ref>

¹³⁴ Ibid., p.297

example the doctor refuses to treat the patient with the infectious disease because of the concern about his own health is considered discriminatory. Thus, one could ask who and what gave the religious beliefs such superior status compare to others beliefs. Savulescu also calls into question the status of doctors or other health care workers as health care professionals who should accept that the interest of their patients should come first. In addition, he reiterates that health care professionals are aware of the responsibility that their profession brings with it towards the patients already during their preparation for such profession and therefore should consider in advance whether they can offer the patients the services in a way that does not hinder the quality and accessibility of legally recognized health care services and if it does so, then they should choose a different specialization.¹³⁵

The fact that conscientious objection does not have a place in health care was made also by Julie Cantor as a response to the new federal regulation of the Department of Health and Human Services enacted in December, 2008 by Bush's administration.¹³⁶ Initially, she emphasizes the requirement of professionalism in the sphere of health care, freed from the self-interest of the health care worker. Afterwards, she explains why conscientious objections do not have a place in health care by differentiating health care and the conscription service. Here she states that unlike in the conscription service - where conscientious objection has its justification, health care workers freely choose their profession and "*[a]s the gatekeepers to medicine, physicians and other health care*

¹³⁵ J. Savulescu, "Conscientious objection in medicine", *BMJ* 2006, 332, 294-297, last accessed on March 16, 2010 at: <http://www.bmjjournals.org/cgi/content/full/332/7536/294?ijkey=6NtRebQvp8GVGYn&keytype=ref>

¹³⁶ J. D. Cantor, "Conscientious objection gone awry – restoring selfless professionalism in medicine", *The New England Journal of Medicine*, Volume 360: 1484-1485, 2009; Number 15, last accessed on March 18, 2010 at: <http://content.nejm.org/cgi/content/extract/360/15/1484>

*providers have an obligation to choose specialties that are not moral minefields for them*¹³⁷. Then, she also compares conscience to a burden which “*patients should not have to shoulder*”¹³⁸. Moreover, her criticism relates to the fact that objections are very unstable and if they have place in health care, the patients can not be sure of what services they can in fact get. There can be different professionals objecting towards different treatment thus making the access to controversial health care service unavailable.¹³⁹

In addition, other critics - Frader and Bosk point out the high status and many privileges that doctors enjoy in society as the fiduciaries of their patients. They rightly consider doctors to be in a better position than their patients and thus claim that any conscientious objection claims are very selfish.¹⁴⁰

John Wyatt also points out that doctors who do not object to the provision of any health care service or treatment must perform these services in the place of those who object. He explains that they can consider such a system to be unjust and decide it is easier for them to claim such objection as well in order to get rid of excessive workload laid on them

¹³⁷ Ibid

¹³⁸ Ibid

¹³⁹ Ibid

¹⁴⁰ Frader J, Bosk. CL, “*The personal is political, the professional is not: Conscientious objection to obtaining/providing/acting on genetic information*”. Am J Med Genet Part C Semin Med Genet 151C:62-67 in

“*Conscientious Objection: A Medical Student Perspective*”, by A. Williams, *Virtual Mentor*, September 2009, Volume 11, Number 9: 686-689, p. 687, accessed on March 16, 2010 at: <http://virtualmentor.ama-assn.org/2009/09/jsc1-0909.html>

because of the other objecting doctors' refusal to treat the patient. This creates the way for the abuse of conscience.¹⁴¹

Besides the opponents to the application of the conscientious objection in health care, there are also those, such as Farr A. Curlin, who believe that it is correct for the health care professionals to refuse the treatment which is opposed to their conscience.¹⁴² However, at the same time he emphasizes that health care professionals still have a duty to inform and refer a patient who approached them. In supporting his argument he offers following reasons: First of all, according to him, “... *you can't have doctors thinking about what's best for their patients and being committed to it, unless you allow them to not do things that they don't think are best for their patients. There's no way to have both.*”¹⁴³ Furthermore he reiterates that: “... *medical decisions cannot be reduced to doing what patients want ...*”¹⁴⁴ And he also considers conscience to be “... *a logical and necessary consequence of physicians exercising discernment or clinical judgment.*”¹⁴⁵

Doctors, however, are not just professionals but also human beings. And the quality of the health care not only depends on the skilfulness of the health care professionals, but also on the approach to the patient and the morality of the doctor. Thus, I believe,

¹⁴¹ J. Wyatt, “*Doctor's conscience*”, *CMF Files*, Number 39, 2009, p. 1-2, access on March 22, 2009 at: http://admin.cmf.org.uk/pdf/cmffiles/39_doctors_conscience.pdf

¹⁴² Curlin, FA, et al. “*Religion, Conscience and Controversial Clinical Practices.*” *NEJM*. 356;6:593-600 in Medical Ethics Advisor, “*Should health care providers have the right of conscientious refusal?*”, December 2009, Vol. 25, No. 12, p. 133-144, p. 135

¹⁴³ Ibid

¹⁴⁴ Ibid

¹⁴⁵ Ibid

requiring the doctors to act contrary to their deep conscientious beliefs could affect the quality of the service they would be compelled to perform.

Moreover, even though the demand on the students of medicine to think about their future specialization already during their preparation for practice in a way that they should choose the specialization comprising health care services to which they do not conscientiously object is justified, one can not avoid situations where such conscientious objection can develop in the doctor's perception later throughout his practice. For example, the female doctor who after multiple miscarriages is not able to bear the child she desires so much, can be reasonably expected to rely on the objection and refuse to perform the abortion. Still, this doctor could be a great professional, offering all the available health care services and treatments of a high quality to her patients but this one. Compelling her to act against her conscience could result in harming not just her personal integrity, but also the patient or result in good professionals leaving the field of medical care to which they devoted themselves.

Furthermore, another fact that supports the acceptability of the conscientious objection in health care services is that not all the doctors invoke objections. Thus, if states can still manage to safeguard these reproductive health care services that would be of a good quality and available in appropriate time then there is no reason not to allow the objections.

Here, I would like to return to the statement of Julian Savulescu about the place of values and conscience in medicine. He states that: "*The door to ‘value-driven-medicine’ is a door to a Pandora’s box of idiosyncratic, bigoted, discriminatory medicine.*"¹⁴⁶ However, the Pandora box has already been opened. Many countries already regulate the conscientious objection in the field of health care. As can be seen from the example of the USA, UK and Slovakia in Chapter 2 of this paper, it is clear that the regulation of the conscientious objections varies from state to state. They differ in the scope of regulation and limitations. While Mississippi has almost absolute and unlimited clause on the use of conscientious objections¹⁴⁷, the UK provides certain limitation in its legislation and guidance that order objecting doctor to inform the patient and refer him to another professional thus moving towards the reasonable balance between the health care professional as conscientious objector and individual requesting the treatment.¹⁴⁸ And even though Slovakia regulates the conscientious objection as well that entails the threat to life or health of the patient as the limitation for the invocation of conscientious objection, this regulation is very general, opening the door to ambiguity in its future application.¹⁴⁹

Therefore, in the next section and on the basis of the information gained throughout the research on this topic I will introduce what kind of limitations should be placed on the

¹⁴⁶ J. Savulescu, "Conscientious objection in medicine", *BMJ* 2006, 332, 294-297, p.297, last accessed on March 16, 2010 at:

<http://www.bmjjournals.org/cgi/content/full/332/294?ijkey=6NtRebQvp8GVGYn&keytype=ref>:

¹⁴⁷ See Chapter 2.1.

¹⁴⁸ See Chapter 2.2.

¹⁴⁹ See Chapter 2.3.

application of conscientious objection in health care practice and thus what would be the best model for its regulation.

3.2. Limitation of conscientious objection and the best model for its regulation

As conscientious objection is already applied in practice by health care professionals, it is necessary to resolve the conflict which it can cause between health care professional's right of conscience and patient's right to access health care services and thus reach legal certainty in this sphere. Various regulations of conscientious clauses show the danger of its extensive use and one should think of what to do in order to reach a balance between the two competing interests. In this section I will offer the model of regulation of conscientious objection in health care comprising the limitations placed on it in order to reach the above mentioned balance.

If the state allows for the usage of conscientious objections in medicine, it should regulate it in its national legislation in a way that fulfils following conditions:

A. Conscientious objection as the right of individual

First of all, the state should make it clear in its national regulation of conscientious objection that only the individuals can invoke it. It should safeguard that no legal personalities such as whole hospitals or health care institutions can invoke it. Freedom of conscience and its manifestation is fundamental human freedom and legal personalities

are not human beings that do not have a conscience.¹⁵⁰ Thus, if hospital would be able to claim conscientious objection, it would go against the basis of this objection. Moreover, if the hospital could claim conscientious objection as it is possible in the USA¹⁵¹, access to health care services would be very much restricted. There would not be a single doctor in this ‘objecting’ hospital able to perform the particular health care service or procedure.

B. Clear specification of health care services towards which conscientious objection can be invoked

Secondly, regulation should clearly specify towards which health care services or treatments conscientious objection can be invoked in order to preserve the legal certainty for patients as well as health care professionals and prevent excessive use of conscientious objection or its abuse.

C. Non-discriminatory specification of grounds for the invocation of conscientious objection

Thirdly, the invocation of the conscientious objection should not be allowed only on the basis of religious beliefs but also on the basis of moral and ethical beliefs. To limit grounds only to religious ground would unjustifiably favor those objectors affiliated to certain religious groups against those without religious beliefs. Here I believe that such objection “*should be based on a deeply held objection to what the patient is asking the*

¹⁵⁰ See Chapter I – on the Freedom of Conscience, Religion and Thought

¹⁵¹ See Chapter 2.1.

doctor to do, not what the patient has done or how the patient lives”¹⁵² as stated by Charles Williams.

D. Invocation of conscientious objection only with respect to health care professionals that directly perform the objected service or directly participate in such service

Fourthly, legislation should specify what constitutes direct participation. It should make clear that indirect participation in the objected health care service such as for example that of the administrative workers typing letters of referral for abortion procedures – a case which was resolved in UK¹⁵³ or the examples when the nurses would refuse to take daily care of a woman who underwent abortion or clean the instruments used in the abortion procedures can not be construed and used as a basis for invoking the conscientious objection and refusing to perform the task.

E. Prohibition of discriminatory approach towards patients by conscientious objector when invoking objection

Fifthly, the legislation should stipulate that the conscientious objection can not be directed towards the particular patient or group of patients but towards the particular treatment. This should safeguard non-discriminatory approach when the conscientious objector objects to the service itself and not to patient because of his sexual orientation, marital status or racial group or other characteristics. Opposite approach would be discriminatory constituting abuse of conscience and allowing the health care

¹⁵² C. Williams, “Conscientious objection”, discussion of doctors’ right to stand by their moral convictions, Student BMJ, Volume 16, July 2008, 264 – 265, to be found at:

<http://archive.student.bmjjournals.com/archive/08/07/life/264.php>

¹⁵³ *Janaway v. Salford Health Authority*, [1989], A.C. 537 (House of Lords)

professionals to refuse the treatment not because the procedure itself but because of disapproval of one's way of life.

F. Disclosure of procedures towards which conscientious objector objects

Sixthly, the health care professional who invokes the conscientious objection should inform the patient about it. In case of health care professionals having a private practice which normally would include the performance of services to which the professional objects, health care professionals should inform the potential future patient before concluding a contract with him about the treatment to which he objects and thus can not offer it in case of future request made by the patient. This will allow a patient to make independent decision on whether he will contract with another non-objecting doctor or whether he will contract with this one and thus take a risk that in the case of future need of such service he will have to see another specialist.

G. Disclosure of the information relating to health state of the patient, his diagnosis, prognosis and possibilities of further treatment

Seventhly, it should be emphasized that the objection invoked does not allow the objecting health care professional to withhold from patient the information on his health state, diagnosis, prognosis and the possibilities of further legally available treatment. On the contrary, this duty must be observed by the conscientious objector. As could be understood earlier in this paper, this duty together with the duty of referral described in the next point was recognized in the UK where the General Medical Council as

regulatory body of doctors laid this duty on them in its guidance.¹⁵⁴ Furthermore, these duties were also mentioned in the Policy Statement of the American Academy of Pediatrics who stipulated that it is the health professional's duty to provide information to patients in order for them to be able to decide autonomously.¹⁵⁵

H. Duty to refer the patient to a non-objecting health care professional

Eighthly, once a conscientious objection is invoked by the health care professional he still has a duty to refer a patient to a non-objecting professional that could perform requested procedure. As mentioned above in point F, referral was already recognized in guidance of UK General Medical Council and Policy Statement of the American Academy of Pediatrics.¹⁵⁶ Of course, in case when the patient is referred to another health care professional, this must be within the patient's proximity and timely accessible in order for the time reserved to the performance of such a service not to lapse. Otherwise it would render objectionable but otherwise legal health care services unavailable.

I. Limitation on the invocation of conscientious objection

Ninthly, the regulation of the conscientious objection should codify that in cases when there is no another health care provider accessible for the patient to perform the requested or necessary service or in emergency cases when there is a risk to life or health of the patient, the doctor originally objecting can not rely on this objection and has to deliver

¹⁵⁴ See Chapter 2.2.

¹⁵⁵ American Academy of Pediatrics, Committee of Bioethics, "Policy Statement – Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience", *PEDIATRICS* Volume 124, Number 6, December 2009, p. 1689-1693, 1689 and 1691, last accessed on March 15, 2010 at: <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;124/6/1689.pdf>

¹⁵⁶ See point F, Chapter 3.2.

the treatment or procedure. As discussed in Chapter 2 of this paper, this limitation in cases of threat to life and health of the patients were recognized in the UK's Abortion Act 1967¹⁵⁷ as well as in the Slovak clause on the conscientious objection included in the Code of Ethics of Health Worker.¹⁵⁸ Such a limitation does not exist in the analyzed Mississippi act on conscience, which gives immunities not just health care professionals but also to health care institutions for refusal of offering even the emergency treatment.¹⁵⁹

J. Securing an appropriate number of non-objecting health care professionals

Moreover, to safeguard an effective access to legally available health care services, hospitals should safeguard appropriate number of health care workers who do not object against provision of certain treatment in order for the patient to have effective access to such treatment. Such personnel set up should avoid situations when there would be a single health care worker not objecting towards particular treatment as in such cases he would have to bear a duty to perform services to which others object himself.

K. Legally available remedies

In addition, regulation of the conscientious objections should also provide for the remedies that could be sought by the affected persons with respect to invocation of conscientious objection.

¹⁵⁷ Abortion Act 1967, Section 4(2), last accessed on March 20, 2010 at:
<http://www.statutelaw.gov.uk/documents/1967/87/ukpga>

¹⁵⁸ Act No. 578/2004 Coll. of 21 October 2004 on healthcare providers, health workers and professional organisations in the health service, and amending and supplementing certain laws, as amended by later regulations, Appendix 4 - Code of Ethics of the Medical worker, clause 3, to be seen at:

http://jaspi.justice.gov.sk/jaspiw1/htm_zak/jaspiw_maxi_zak_fr0.htm

¹⁵⁹ Mississippi Health Care Rights of Conscience Act 2004, section 3(2), last accessed on March 13, 2010 at: <http://billstatus.ls.state.ms.us/documents/2004/html/SB/2600-2699/SB2619SG.htm>

Even though the legislative regulation can not cover all the possible situations - that can arise in the future - relating to the application of conscientious objection in the practice of health care, I believe such regulation, providing for certain basic standards, explanation of terms and boundaries can help to avoid many controversies arising in practice.

Conclusion

At some point in their life all people happen to be in a need of medical treatment and health care. Either immediately after the birth that in the modern societies usually takes place in the medical surroundings or later in their life as a result of serious accidents, but also average flue or other diseases can cause such a need. At such time of the life people tend to look up at the doctors as those who are there for them, to help them, provide them treatment and they want to feel they are cared for properly, with the professional care and humanity.

Many of health care services do not cause conscientious controversies between the health care professionals. However, there are some, especially those related to reproductive services – such as for example abortion procedure, voluntary sterilization or other family planning services that can result in a conflict of interest between the health care professional invoking conscientious objection with respect to particular treatment or procedure and individual's right to access health care. As conscientious objections are being invoked in practice and patients are those who can be adversely affected by the

health care professional's decision not to perform the requested or necessary reproductive treatment or procedure, these objections must be carefully considered and regulated in a way that provides for the best possible balance between these two conflicting interests.

The aim of this thesis was to analyze the appropriateness of the regulation of conscientious objection in the sphere of reproductive health care services with respect to the legal systems of the United States of America, the United Kingdom and the Slovak Republic, in order to suggest what would be the best appropriate model of conscientious objections' regulation in the states' national legislations. With respect to this, the first chapter of the thesis identified sources of conflict of interests arising in the controversial health care service between the health care professional and Patient, namely the health care professional's right to act according to his conscience and patient's right to access health care. Afterwards, the second chapter of the thesis analyzed in the comparative perspective the existing regulation of conscientious objections in the USA, the UK and Slovakia and pointed out that even though there are some similarities there are also major differences. It showed that the regulation in the USA is too excessive covering all kinds of health care professionals as well as institutions and broad range of activities considered to be a participation in procedure thus being protected by conscientious objection clause. Unlike the USA, the analyzed regulation in the UK proved that the UK's regulation on conscientious objection provides a fine limitation on usage of conscientious objection where the participation in the controversial procedure is interpreted narrowly and duties of health care professionals to inform and refer the patient preserved by professional guidance. In addition, analysis of the Slovak regulation showed that despite certain limitations on the invocation conscientious objection – such as threat to life and health, it is too general and vague thus opening the door for future controversies. Consequently, in the forth chapter

of the thesis various opinion on the acceptability of conscientious objection in health care were presented and finally, based on the knowledge gained through the research and done analysis, the best model for regulation of conscientious objection was presented. This model suggested that conscientious objection is the right of individual, not institutions and that its regulation should exactly specify towards which health care services it can be invoked. At the same time it should only cover the direct performance or participation in the controversial treatment. However, even in such cases the duties to inform and refer a patient must be observed and if the person's life or health is threatened or if there is no another non-objecting health care professional available, the one objecting has to perform the service anyway. Non-discrimination rule applies and legal remedies must be also in place in order to enforce the rights.

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