# *CONSCIENTIOUS OBJECTION IN REPRODUCTIVE HEALTHCARE IN SOUTH AFRICA IS UNCONSCIONABLE*


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# 1. INTRODUCTION

## 1.1 Background

Studies show that between 39 – 41% of pregnancies are unintended (Ahrens et al., 2018) and (Singh, Sedgh, & Hussain, 2010). A majority of unwanted pregnancies; up to 86% occur in the developing world. In South Africa, unintended pregnancies could be as high as 84% of all pregnancies (Haffejee et al., 2017). Ahrens et al., (2018) write that unintended pregnancies are associated with adverse health and socioeconomic outcomes.

Women with unintended pregnancies face a moral dilemma whether to terminate the pregnancy or to carry it to full term and birth. The (2010) study by Singh, Sedgh and Hussain reported that globally, it is estimated that 39% of unintended pregnancies result in live births, while roughly 48% end in abortions with the rest ending in miscarriages (Haffejee et al., 2017). Approximately 22 million unsafe abortions are carried out each year, increasing maternal mortality and morbidity. A legal abortion performed by qualified healthcare professionals in facilities that conform to minimal medical standards is one of the safest medical procedures in medical practice with very low morbidity and insignificant risk of death (Grimes et al., 2006).

In South Africa, the Choice of Termination of Pregnancy (CTOP) Act Number 92 came into force in February 1997 (Harries, Cooper, Strebel, & Colvin, 2014; Ngwena, 2004). CTOP Act strengthens reproductive rights enshrined in the South African constitution in 27(a) (McQuoid-Mason, 2010b) allowing legal termination of pregnancy up to 12 weeks and beyond. CTOP Act replaced the restrictive Abortion and Sterilisation Act of 1975 which resulted in an estimated 200 000 unsafe abortions with forty-five thousand hospital admissions and 425 deaths annually (Morroni, Buga, & Myer, 2006).

However, as McQuoid-Mason writes, the constitutional right to reproductive health, reinforced by section 12(2)(a) (which states that everyone has the right to "bodily and psychological" integrity which includes the right to make autonomous decisions regarding their reproductive health) is limited by section 15(1). This section of the constitution appears to give healthcare professionals the right to refuse to perform abortion based on freedom of conscience, thought, belief and/or opinion.

Some health care professionals hold the view that human foetuses are innocent persons who have done no wrong and that to terminate their lives in an abortion is not only morally wrong but should be considered unjustifiable murder (Helga Kuhse, Schuklenk, & Singer, 2016 p.11). The counterargument to this cited in the same publication (p.23-34) holds that foetuses are not persons and that for foetuses to be persons, they have to possess a concept of the "self" and the will to continue living. *A Defence of Abortion* by Judith Thomson in the above publication (p.38 – 47) argues that the personhood argument equates the rights of the foetus to that of the mother but the right to bodily integrity of the mother trumps the foetus' right to life based on the fact that it must use the mother's body to survive. I will argue in this research report that these theoretical arguments do not give the healthcare professional the right to unqualified objection to professional duties which are legally and morally due and which the state is bound to provide (Savulescu & Schuklenk, 2017; Schuklenk & Smalling, 2017).

## 1.2 Rationale

The need for termination of pregnancy services in South Africa is huge (Haffejee et al., 2017; Harries et al., 2014; Teffo & Rispel, 2017). It has been noted that conscientious objection to abortion contributes to what can only be called a

reproductive health crisis (Amnesty International, 2017). Most of the literature on abortion in South Africa is empirical or legalistic. What this research shows though is that unregulated conscientious objection contributes directly to unsafe abortions with a high rate of mortality and morbidity. Despite this, a proper analysis of the ethical basis of conscientious objection to abortion in South Africa is lacking. Such an analysis is required to mediate between the right to personal autonomy (to choose an abortion or refuse to perform one) and the duty of the state to provide reproductive health services.

The question whether conscientious objection is morally right or wrong has been addressed by several authors (Cowley, 2016; Savulescu & Schuklenk, 2017; Schuklenk & Smalling, 2017). Some authors argue that legislative clauses that allow conscientious objection are always wrong, stating that morality in medicine demands that the patient comes first (Stahl & Emmanuel, 2017). In South Africa, Ngwena and McQuoid-Mason have approached this question only on the basis of what is right in law. In law, healthcare professionals in South Africa appear to have an unqualified right to conscientiously object to abortion except when there is clear and imminent danger to the mother's life and this danger is determined by the healthcare professional.

Stahl & Emmanuel (2017) define conscientious objection in health care as "the legal right of a health care professional to cite their personal religious or moral beliefs as a reason to opt out of performing specific procedures or caring for particular patients". Shanawani (2016) offers a very similar definition of conscientious objection as "the refusal to perform a legal role or responsibility because of personal belief". The paper goes on to say that in health care, conscientious objection means refusal to provide certain treatments based on reasons of morality or conscience. In both definitions,

there is a refusal to provide professional services based on personal belief. The second definition differs slightly in that it suggests that such refusals can be based on reasons of morality. A third definitions says “a person engages in an act of conscientious objection when she refuses to perform an action, provide a service, and so forth on the grounds that doing so is against her conscience” (Wicclair, 2011 p1). These definitions based on a legal right to personal beliefs, or “reasons of morality”, or conscience do not say whether conscientious objection is morally right or wrong. An ethical analysis of the moral content of conscientious objection and the right to conscientiously object may help inform regulation of conscientious objection in South Africa.

Amnesty International (2017), state that only the Western Cape Province of South Africa has some regulation of conscientious objection. However, it does not specify what these regulations are. Harries (2014) writes that healthcare professionals who conscientiously object to abortion are required to lodge this objection in writing with the employer. But this process is poorly managed, and there is no oversight by managers of hospitals and clinics. Since guidance is lacking, this study hopes to make recommendations for the regulation of conscientious objection in South Africa.

## 1.3 Thesis Statement

I will argue that the status quo regarding conscientious objection to medical abortion in South Africa is unethical and that conscientious objection requires regulation.

## 1.4 Aims and Objectives

The aim of the study is to critically appraise the moral basis of conscientious objection as it applies to termination of pregnancy services in South Africa.

Study Objectives:

- To argue that conscientious objection in South Africa goes against a health care professional's oath and promises and thereby conflicts with Kantian morality.
- To claim that conscientious objection to abortion in South Africa runs counter to key ethical and professional virtues.
- To argue that conscientious objection to abortion in South Africa in practice violates the principle of patient autonomy.
- To argue that conscientious objection to abortion in South Africa causes harm and therefore violates the principle of non-maleficence.
- To demonstrate that conscientious objection to abortion in South Africa undermines the principle of distributive justice through failure to equitably allocate important human resources.
- To identify and defend ideas for regulation of conscientious objection to abortion in South Africa.

## 1.5 Research Design

This report is based on a purely normative study that involved reviewing literature on cases of conscientious objection to reproductive health in South Africa. The main thrust was to apply the arguments in existing literature for and against conscientious objection to medical termination of pregnancy in the South African context.

### 1.5.1 Research Methods

Electronic databases such as Google Scholar, PubMed, JSTOR, etc. were used to search for scholarly articles on the topic. Initially, search words such as “freedom of conscience”, “conscientious objection”, “abortion”, “termination of pregnancy” and “South Africa” were used. Articles were selected based on their relevance to the topic and whether they use normative ethical theories to justify or reject conscientious objection. Then, the primary search words were used in conjunction with selected normative ethical theories such as “deontology freedom of conscience” or “virtue ethics conscientious objection” or “autonomy termination of pregnancy”. Articles were selected from the results in the same manner as above. Relevant laws and regulations in South Africa were also accessed and reviewed based on their relevance to the topic. The arguments made in the following chapters were developed from the literature reviewed.

## 1.6 Argumentative Strategy

To address the stated objectives, I use a mix of ethical theories to make the case that conscientious objection in South Africa is unethical. The theories I use in the following chapters were chosen to cover the broad categories of normative moral theory namely: deontology, utilitarianism and virtue theory. No chapter is dedicated to utilitarianism as there is considerable overlap with beneficence and non-maleficence which can be used as a quick guide to moral decision making. In the first and second chapters, I use Kantian deontology and virtue ethics to argue that legislation allowing unregulated conscientious objection is unconscionable in South Africa. Thereafter, in chapter 3, I use three further arguments stemming from Beauchamp and Childress’ principlism

(Beauchamp & Childress, 2012) to show that conscientious objection in reproductive health in South Africa is unethical. According to Muirhead (2012), the four principles of autonomy, beneficence, non-maleficence and justice should guide ethical decision making.

### 1.6.1 Kantian Promise Keeping and Medical Oaths

Kant's moral philosophy focuses on the duties (obligations) of a moral agent, in this case a health care professional in South Africa. A health care professional in South African is bound by the Geneva declaration which has as a clause the statement "*I will not permit considerations of age, disease, or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient"* (Khan, 2005). I argue based on Kant's philosophy that a health care professional in South Africa has a duty of care towards her patients. To refuse to treat in case of abortion based on conscientious objection is to break her promise in the Geneva declaration which is implicit in taking up the profession.

### 1.6.2 Virtue Ethics

Virtue ethics is not only concerned with finding out what is good but with becoming a good person. The objective of virtue ethics is individual happiness and achieving *Eudaimonia* or happiness and flourishing (Proctor, 2019). The essence here is that a person of good character doing what is right at the right time in the right way is a happy person. We achieve this by practicing virtues such as integrity, compassion, conscientiousness, trustworthiness etc. (Koch & Menezes, 2015). I argue that there is no compassion or conscientiousness in conscientious objection. In fact, conscientious objection to reproductive health is vicious in that it often embodies the vices of callousness and dishonesty. This of course does not engender trust in the

doctor/patient relationship. Consequently, conscientious objection allows neither the patient nor the health care professional to reach their potential (flourish).

### 1.6.3 Principlism

The principle of ***autonomy*** in ethics is enshrined in the South African constitution. It gives patients the right to make decisions about their health without external influence (Javier & Correa, 2013; Varelius, 2006). The argument I make is that a woman seeking reproductive health services has the sole right to decide what happens to her body. Conscientious objection infringes on her right to autonomy and bodily integrity. The doctor patient-relationship in South Africa is characterised by paternalistic attitudes which are unethical (Manyonga Howard, Graham Howarth, Mark Di nwoodie, Paul Nisselle, 2014). The autonomy of the healthcare professional to make her own decision to participate or not in the abortion should be considered. Nevertheless, I will argue here like Savulescu and Schuklenk, 2017 that the onus ought to be on the healthcare professional to prove that she holds the view and is not being influenced by considerations outside her control such as unreflected socialisation, manipulation, or coercion (Varelius, 2006).

I will also argue that conscientious objection in South Africa causes enormous harm and therefore violates the principle of ***non-maleficence***. The link between unsafe abortions and maternal mortality is well established (Amnesty International, 2017; Grimes et al., 2006). Conscientious objection is treatment refusal which violates the principle of non-maleficence (Fiala & Arthur, 2017a).

In terms of **distributive justice**, I argue that in South Africa demand for abortion services is very high with up to 84% of all pregnancies being unintended conscientious objection limits the availability of a scarce and vital human resource. The public health

sector is severely underfunded with severe shortages of equipment, medicines and properly trained personnel (Petchesky, 2000). An often-quoted statistic in South Africa is that 84% of the population depend on the public health system. Those who are able to afford private healthcare have access to proper medical services including medical termination of pregnancies. Harries et al., 2014 write that some healthcare professionals claim conscientious objection to abortion in public hospitals but are willing to provide these services in the private sector. The principle of justice which holds that burdens of health should be shared equitably is violated. The argument here is that the state is wrong in not regulating conscientious objection, which violates the principle of ***justice***. The state has a duty to address the unequal access to reproductive health care.

On the basis of these arguments I will conclude that the status quo regarding conscientious objection to reproductive health in South Africa is morally unjustified and discuss proposals that might improve the current situation. I will argue that there is no place for personal "moral" beliefs in reproductive medicine. While it may be permissible in some extreme cases to refuse termination of pregnancy services on the basis of verifiable biological or medical facts or some normative theories such as virtue ethics, treatment refusal on the basis of "conscience" ought to be disallowed. In South Africa, conscientious objection ought to be overruled when the life of a woman is in danger. I will argue that the default position should be that conscientious objection is morally unjustified unless in extreme cases where the psychological wellbeing of the health care professional is verifiably threatened and therefore should not be allowed in South Africa.

I examine the proposal that healthcare professionals who wish to conscientiously object to legal and professionally sanctioned medical services should be required to

apply to an authority such as national or provincial ethics committees or the Health Professions Council of South Africa for permission to do so. Such ethics committees would apply clear evidential guidelines for justified conscientious objection. This report draws the conclusion that no moral justification exists to refuse treatment based on conscience i.e. personal “moral” beliefs. However, forcing health care professionals or anyone else to do what they do not want to do may cause serious psychological harm. Such committees should grant health care professionals with the potential for harm the permission to practice in other fields of medicine where they do not have to make decisions that may affect their psychological wellbeing.

I also examine the morality of regulating conscientious objection by requiring applicants to South African medical schools to register their objection to reproductive health services up front. Applicants should be required to morally justify their objection to reproductive health services.

## 1.7 Ethics

Ethical approval is not required for this normative study that does not use human or animal participants. The study will also not use any information that can be considered private or that can be traced back to an individual. An ethics waiver is included in this submission.

## 1.8 Research Outcomes

It is hoped that this report will make a contribution to developing guidelines for the regulation of conscientious objection in South Africa. At the moment, only the Western Cape Province regulates conscientious objection.

A journal publication may also come out of this study. It will add to the existing body of knowledge on conscientious objection from a South African perspective.

## 1.9 Problems

There are no major limitations to this study. For the purposes of the normative analyses, enough empirical research in South Africa is available to draw from.

## 1.10 Overview of Sections

- Introduction and Background
- Kantian Morality
    - A healthcare professional's oath and promise to care
    - The state's duty to protect the freedom of the patient to choose
- Virtue ethics
    - Conscientious objection conflicts with important virtues and does not allow the patient or the health care professional to reach their full potential
- Principlism
    - Conscientious objection violates the principle of autonomy
    - Conscientious objection allows harm and therefore violates the principle of non-maleficence
    - Conscientious objection allows the unequal distribution of harms in reproductive healthcare. It violates the principle of justice
- Conclusion

- No conscientious objection except in cases where performing abortion may cause serious psychological harm to the objector.
- Applicants to medical schools should be screened for religious and personal views that may prevent them from performing professional and moral duties.

# 2. Medical Oaths and Kantian Ethics

## 2.1 Introduction and Key Concepts

In this chapter, I argue that conscientious objection to termination of pregnancy in South Africa goes against a health care professional's duties as embodied in medical oaths and thereby conflicts with Kantian morality. I argue that conscientious objection goes against both duties of commission and duties of omission.

In order make my arguments clearer, I begin with some background information on some of the key concepts in this in this chapter. It is important to define these concepts as they are also relevant to the entire report. Only a brief description is presented here but I provide an in-depth discussion on how these apply to conscientious objection in South Africa in each chapter below.

- Medical Oaths and Promises
- Morality
- Duty
- Freedom of Conscience

### 2.1.2 Medical Oaths and Promises

Oaths in ethics are statements of moral norms and principles that guide the conduct of group or profession or an individual. These include formal declarations such as the World Medical Association's Declaration of Geneva also known as the Physician's pledge derived from the ancient Hippocratic Oath. It is said that oaths in medicine encompass some truth with a promise/intent to act according to some moral rule

(Hurwitz & Richardson, 1997). The basic promise of medical oaths is that the health care professional:

1. will work for the good of her patient.
2. will cause her patient no harm.
3. will honour the profession of medicine and protect it from corruption.
4. will hold all medical information in confidence.

Whereas professional codes of conduct have the law as guarantor, oaths such as the Hippocratic Oath have historically invoked a divine agency (Apollo) as the guarantor of the oath-taker's moral integrity and honesty. Conversely, the wrath of the gods is called upon the oath-taker should s/he fail to perform his/her duty according to the oath (Hulkower, 2010). This of course does not apply to secular medical oaths. Conscientious objection seeks the help of the law to exempt objectors from performing their duties.

Oaths remind the health care professional of their moral obligation to their patients and society at large. It is important to note that oath-takers willingly take these and are therefore bound by the moral obligations enshrined in them. In general, medical oaths in their various forms (either as an oath or declaration or professional code) promise compassion for the suffering and respect for the dignity of all human beings without any qualification. Medical oaths do not promise to care for people except when they are pregnant with a malformed baby.

### 2.1.3 Morality

A descriptive definition of morality is very difficult to come by. In everyday language, morality simply means doing what is right according to the values and norms accepted by most members of society. The existence of large and heterogeneous societies

brings about conceptual issues with this simplified definition of morality (Bernard & Joshua, 2017). The minimum conception of morality views it as the “effort to guide one’s decisions and actions by reason. It is to decide and to do that which there are best reasons for such a decision or action  while giving equal consideration to the interest of each individual affected by one’s decision and/or action” (Rachels & Rachels, 2012).

This minimum conception of morality gives us the basic tools to judge decisions and actions morally right or wrong. Rachels and Rachels describe a conscientious moral agent as:

> “[S]omeone who is concerned impartially with the interests of everyone affected by what he or she does; who accepts principles of conduct only after scrutinising them to make sure they are justified; who is willing to listen to reason even when it means revising prior convictions; and who, finally, is willing to act on the result of this deliberation.”

This definition and the expectations of a conscientious moral agent are especially important in the field of bioethics where moral dilemmas abound.

The discipline that studies moral values and moral reasoning is called ethics. In bioethics (health care ethics), we apply moral philosophical reasoning to complex issues like conscientious objection to termination of pregnancy or euthanasia. The main purpose is to determine best reasons for or against taking a particular course of action. In that regard, we follow normative ethical theories which attempt to define and distinguish between morally right and wrong action.

### 2.1.4 Kantian Deontology

In this section, I will use the ethical theory of deontology, of which Immanuel Kant is the greatest proponent, to argue that health care professionals have a duty not to conscientiously object to the termination of pregnancy. A brief outline of Kantian deontology will be presented below.

*Kantian Ethics* – the basic framework of deontology ("*deon*" from the Greek meaning obligation or duty) holds that "*an action is right iff it is in accordance with a moral rule or principle*" (Hursthouse, 1991a). Whereas moral rules were historically laid down by some supernatural entity such as God or natural law, Immanuel Kant sought to determine moral rules and principles by reason alone. In order to determine what is morally right or wrong, Kant proposed what he called the categorical imperative. An imperative is hypothetical if it is a means to something else, but categorical if it commands the right conduct or act without being a means to something else. The first formulation of the categorical imperative states "Act only in accordance with that maxim through which you can at the same time will that it become a universal law*"* (Schafer-Landau, pp.493). In essence, an act is morally right if the rule on which the act is based can be universalised without contradiction.

Kant also argued that human beings possess intrinsic worth or dignity because they are rational agents (Rachels and Rachels, 2012 p.137). That is, human beings are capable of making the rules of what is morally right or wrong and adjusting their conduct according to these rules. Moral goodness in Kant's view only comes about when rational creatures decide and act based on good will or knowing we have duties towards fellow man.

#### 2.1.4.1 Moral Duty

Duty is defined as an action to which one is bound (Khan, 2005). Only actions motivated by a sense of "duty" (i.e. actions motivated from a sense of being bound) have moral worth according to Immanuel Kant. A moral duty or obligation arises out of consideration of what is right or wrong to do. We can be motivated by sentiment, but sentiments change over time, and we do not all have the same sentiment at all times (Hill, 2009 p36). A moral duty can only be thought of in terms of "*ought to do*" or "*must do*" irrespective of how one feels about it. If an action is good as determined by a moral rule, then it ought to be done.

Kant distinguishes between juridical duties and ethical duties. Juridical duties are those that can be enforced from outside such as those enshrined in the constitution. While ethical duties arise *a priori* from the rational capacities of the moral agent; this ought not be enforced from outside, for to do so is not morally right (Hill, 2009 p. 229). There are perfect duties (negative) which prohibit us from doing something at all times and imperfect duties (positive) which require us to do something (Robinson, 2018).

### 2.1.5 Freedom of Conscience

In this section, I present a definition of conscience in order to clarify what it means when conscientious objectors cite freedom of conscience as a reason not to participate in reproductive health care. And of course, why I dismiss conscience as not having any moral content.

There are several views of conscience, making it difficult to understand what one means by freedom of conscience. In one view conscience is a human faculty similar to the intellect, the will and imagination. The intellect discerns truth, while the object of the will is goodness and that of imagination beauty (Leach, 2014). In this view, the

object of conscience is to discern moral truths, more like a window of the mind which observes morality that exist in the world a compass that directs an agent's action towards moral truths (Symons, 2017). This view of conscience is morally neutral because it is not connected to any specific moral theory.

Conscience can also be viewed as an inner moral judge that assesses an agent's actions as morally good or bad, acceptable or unacceptable (Strohm, 2011 p.47-48). In this view, conscience is an inner independent judge or court of our character. There is a self that acts and a self that observes the conduct of the first. Immanuel Kant had this view of conscience stating "*for all duties of man's conscience will, accordingly have to think of someone other than himself…… as a judge of his action*" (Strohm, 2011 p.46). Giubilini (2016) says the conception of conscience is illustrated by Mark Twain's Huckleberry Finn. Huck feels guilty for helping his slave friend Jim escape his owner Mrs Watson. These guilty feelings come from within Huckleberry who is torn between doing what he thinks is the right thing by his friend and the socially accepted principles of the time that Jim was the property of Mrs Watson.

There are other conceptions of conscience, including one from Kant that views it as the motivation to perform our duties. In this view, conscience prompts us to do what is right. The important point here is that it seems conscience does not have any moral content. It appears to be an empty box that can be filled with any moral content (Giubilini, 2016). It can be used to defend one position say against termination of pregnancy and to defend the exact opposite (Strohm, 2011 p120). For instance, in a paper in 2009 in South Africa, two practicing health care professionals who are Catholics displayed different practical attitudes towards termination of pregnancy based on conscience (Harries, Stinson, & Orner, 2009).

These views of conscience as a human faculty or inner judge make conscience part of one's identity. Hence the common view that conscience has to do with deeply held personal moral beliefs. Conscience does not claim nor present evidence of moral objectivity. It simply holds these views which form part of the identity of the agent. In this view, to talk of the freedom of conscience is to talk of the freedom of the person. Conscience becomes part of someone's identity just as their race or something about them which they cannot change.

The view I take in this research report is that of conscience as an empty box which can be informed with normative moral content. I disagree with the view that conscience informed by personal religious beliefs ought to be used to justify not providing professional services, firstly, because conscience informed by the same religious belief can yield contradictory actions, secondly, because there are too many religious beliefs and different interpretations of the same belief that there is bound to be no consistency in decisions made. Consistency or uniformity of action, as we will see below, is not only important in moral philosophy but also in a scientific field such as health care. There is no evidence that conscience on its own can make morally acceptable decisions. I therefore take the view that decisions made on the basis of the "black box" of conscience ought not to be permissible when it comes to termination of pregnancy. Conscience requires moral content that can be derived from normative moral theories of which I have chosen Kantian ethics, virtue theory and principlism (not a moral theory) as representatives. These cover most core ideas in the major ethical theories.

**Conclusion**

This introductory section on the core concepts provides the basic tools to answer the complex question of whether conscientious objection to the termination of pregnancy is morally right in the context of South Africa. First, I have shown that the purpose of medical oaths and promises is to guide the conduct of health care professionals towards doing what is good for the patient and to cause her no harm. Secondly, I have established that morality requires that health care professionals as moral agents scrutinise their decisions and actions taking into account the interests of everyone affected by what they do. And lastly, I have shown that using Kantian ethics I can derive specific duties for health care professionals from medical oaths. This is the subject of the next section in this chapter.

## 2.2 Duties in Medical Oaths

In this section, I explore the ethical duties inherent in the Declaration of Geneva derived from the Hippocratic Oath. Using the moral reasoning of Kantian deontology, I will argue that this oath holds an imperfect duty of beneficence, which is the duty of care arising from the special doctor-patient relationship. In addition, the case will be made that in the case of South Africa, these oaths hold a perfect duty not to conscientiously object to termination of pregnancy. This is because in failing to uphold the oath conscientious objectors violate the duty not to cause harm.

Medical oaths taken at universities throughout the world including South Africa contain ethical principles that physicians and society at large believe are essential to health care practice. Oaths like the Hippocratic Oath originated as a form of social contract between society and medical practitioners (Helmich & de Carvalho-Filho, 2018) and have been used intentionally to prevent the abuse of the core values of medicine. In

this regard, medical oaths and ethical codes regained significance following the Nuremberg trials of 1947, which exposed the atrocities of the Nazi regime in Germany. This resulted in the Nuremberg Code which provides stringent guidelines for the protection of human participants in research. The following year saw the adoption of the Declaration of Geneva (or Physician's Pledge) by the second General Assembly of the World Medical Association in September 1948. Essentially, this declaration is a modern reincarnation of the Hippocratic Oath that has guided ethical medical practice for more than two and half millennia.

The Physician's Pledge or Declaration of Geneva "outlines in concise terms the professional duties of physicians and affirms the ethical principles of the global medical profession" (Parsa-Parsi, 2017). These duties are listed and discussed in detail in this section. In taking the oath, health care professionals publicly promise to be committed to these duties. As Kant would put it, the health care professional promises to practice not from her feelings or "inclinations" but to be motivated by a sense of duty. Essentially, the health care professional promises not to practice medicine according to personal religious or "moral" believes. A psychological conflict between her duties and personal religious or "moral" beliefs does not arise, as is discussed below.

### 2.2.1 I solemnly pledge to dedicate my life to the service of humanity

The word *dedicate* in this oath implies a commitment or an "obligation" to use medical skills obtained at university for the service of humanity. That is, to practice medicine out of sense of duty or obligation (*I ought to serve* humanity). Taking the oath constitutes a promise to society that a health care professional will act in a particular way. It is only action undertaken out of a sense of duty to keep the promise inherent

in the oath that has any moral worth, according to Immanuel Kant (Kant, 2013). Humanity in this context can be understood in two senses: First, to serve humanity as in all human beings and secondly, to serve with the ethical qualities that make us human, such as compassion, fellow feeling, sympathy, kindness, goodness, generosity of spirit etc. This pledge establishes the ethical principle of justice, to serve all human beings, i.e. not to discriminate between people based on the treatment required. And it also establishes a duty of virtue through the second meaning of humanity i.e. to serve with kindness, goodness, compassion etc. I will now look at the two duties in detail with regards to conscientious objection in South Africa.

#### 2.2.1.1 Service of humanity

The pledge is to dedicate the health care professional's life to the service of all humanity within the scope of professional practice. As Schuklenk and Smalling, (2017) put it, health care professionals ought to cater uniformly to everyone within the scope of their professional practice. The health care professional who conscientiously objects to the termination of pregnancy fails in her duty to dedicate her life to the service of all humanity in that they serve everyone within the scope of their practice except those seeking a termination of pregnancy. Schuklenk and Smalling (2017) argued that for the same reason that it is not acceptable for a female Muslim health care professional to refuse to treat a male patient, health care professionals cannot morally justify not treating a pregnant woman seeking a medically indicated and safe procedure. To do so will amount to picking and choosing those we can serve based on personal religious and "moral" beliefs which are not good reasons according to Kantian morality but are mere sentiments.

Kantian deontology derives the moral maxim "*health care professionals ought to serve everyone uniformly*" from this pledge. All actions that conform to this moral rule are

then judged to be morally good while those that do not conform are morally wrong. This moral maxim or rule establishes what Kant calls an imperfect duty (i.e. that cannot be ignored by moral agents but admits of multiple means of fulfilment). Kant gives two examples of imperfect duties, which are the duty to improve oneself and the duty to help others (Kant, 2013 p.496-497). As highlighted under section 2.1.4.1 imperfect duties are duties of commission which require the moral agent to do something. Kant also points out that that to serve humanity means moral agents have a duty to treat humanity as an end not a means to an end. Treating humanity as an end, means to promote their welfare, avoid harming them, respect their rights and to endeavour as far as possible to further the ends of other human beings (Rachels & Rachels, 2012 p.138). In this case, it means health care professional as far as possible have to promote the ends that their patients desire. Conscientious objection is unconscionable because it does not conform to the moral rule to serve all humanity because it refuses to serve pregnant women seeking reproductive health services. Conscientious objection also does not treat humanity as an end.

The duty to aid others presents the problem of how far a moral agent ought to go to help others without causing harm to herself. Conscientious objectors may agree that they indeed have a duty to help everyone but to do so will cause them serious psychological harm preventing them from providing medical assistance to others in need. This argument can be furthered on the grounds of Kantian deontology that a health care professional has a duty to herself to improve her own wellbeing by not providing reproductive health services to those in need. This of course does not make conscientious objection (refusal to provide medically-indicated services based on reasons other than sound moral objectives or medical indication) morally right. It only establishes an imperfect duty to herself which admits to multiple means of fulfilment.

The best way to fulfil this duty would be to remove herself completely from situations where she is called upon to act in ways that cause her psychological harm. She could choose brain surgery or electrical engineering where there may not be such conflicts between her professional duties and her religious beliefs.

A second counterargument is that the health care professional has the same moral duty to all humanity including the foetus. The theoretical argument about the status of the foetus as a person is beyond the scope of this report. Suffice it to say that a valid Kantian moral duty towards the foetus can only be established on the basis of morality and not on the basis of personal religious beliefs. Moreover, in terms of the duty established in this section, to prioritise the moral duty to the foetus over moral duty to the mother based on personal religious beliefs is to pick and choose who to serve and who not to serve. Besides, in some cases of neural tube defects were children may be born without a brain, it can be successfully argued that to terminate the pregnancy is compassionately serving the foetus.

#### 2.2.1.2 Virtue of humanity

The Pledge also includes the duty to serve humanely or with the ethical qualities that make us human. I derive this duty from the second meaning of the word “humanity” in the pledge. Which are the qualities such as compassion, fellow-feeling that make us human. This second duty perhaps goes to the core of the social contract nature of medical practice. For to act kindly, to act with compassion, or with a generosity of spirit, is to act for the benefit of others. This pledge establishes what has been called a duty to care (Khan, 2005), which holds that those with the means to help others should do so. Kant argued that everyone has a duty to act benevolently within their means. The example often used is that where one sees a child drowning and one has the skill to save the child. Is it possible to universalise the maxim “*I will not help a drowning child”*

or "*no one should help a drowning child"*? This similar to the situation where the health care professional has the technical skill and the vulnerable teenage pregnant girl is about to be drowned by the complexity of motherhood perhaps with no support. Since we cannot, without contradiction, universalise the maxim that health care professionals with the skill to help should not help, Kant holds that this establishes a duty to care – to act benevolently.

The duty of virtue is expounded on in the chapter on virtue ethics. It is only important here to state that conscientious objection in principle is inward looking towards personal religious and moral beliefs rather than the outward looking virtues of kindness and compassion. According to the Pledge, the health care professional promises to serve humanity but instead, conscientious objection serves personal "moral" and religious beliefs. She serves herself and not humanity in its entirety as The Pledge says.

### 2.2.2The health and wellbeing of patient ought to be my first consideration

In applying the technical skills at the disposal of the health care professional, she promises a patient-centred approach. Whereas the previous part of the pledge applies to all human beings, the second promise in the Declaration of Geneva focuses on the individual patient's health and wellbeing. It is perhaps important to clarify here that the "health" of the patient does not merely mean absence of disease. The Preamble of the Constitution of the World Health Organisation (WHO) defines health as "*a complete state of physical, mental and social well-being*" (Ereshefsky, 2009; Nobile, 2014). In this regard, the health care professional pledges not only to focus on disease state for which they are trained but also on other aspects such as the mental state and other social determinants of health. This is especially important in the context of pregnancy

and childbirth, which are not only biological events but also have wide-ranging cultural and societal implications. The moral requirement to put the health and well-being of the patient above all else is of course not limited only to the situations where there is a medical indication such as imminent danger to the pregnant woman's life, or severe deformity of the foetus to such an extent that their life would be limited to mere existence. A pregnant teenager may elect to terminate the pregnancy because she is emotionally and psychologically not ready to take on the enormous task of motherhood, or because she does not have the financial and family support to give the baby a fulfilling life. In order words, the South African health care professional pledges that to act morally; she has to consider all factors including physical health, and the cultural and socioeconomic determinants of health. This of course is not the case with conscientious objection meaning refusal to consider factors other than the health care professional's personal religious and "moral" beliefs.

From this pledge, Kantian ethics derives the simple moral rule that "the health and wellbeing of the patient ought to come first at all times". For the Pledge means "*I promise to put the health and wellbeing of my patient first at all times*". To act out of motivation to keep the promise is morally good according to Kantian ethics. A decision or an act is morally good in this case if it complies with the rule that the health and well-being of the patient ought to come first. Conversely, a decision such as conscientious objection is immoral because it does not comply with the moral maxim that the health and well-being of the patient ought to come first.

Khan (2005) stated that an analysis of Kant's moral philosophy shows he would have advocated a universal duty of care under all circumstances. If it is good to place the interest of the patient first, then it ought to be so in all circumstances without limit. Khan uses the example of Severe Acute Respiratory Syndrome (SARS) to argue that

health care professionals have no moral justification for placing their fear and anxiety of infection over the health and well-being of the patient. Likewise, there is no moral justification for treatment refusal in the case of conscientious objection based on psychological harm to the health care professional.

### 2.2.3 I will respect the autonomy of my patient and dignity of my patient

A major revision of the Declaration of Geneva took place in 2017. Prior to that, the declaration had received only minimal changes over the last seventy years. In the latest version, it was deemed necessary to explicitly include respect for patient autonomy. This moral rule is central to the doctor-patient relationship. This will be further explored in the chapter on Principlism. I will only state here that conscientious objection to termination of pregnancy does not respect the autonomy of the patient. Women who seek these services have already made the autonomous choice to terminate their pregnancies. Of course, the autonomy of the health care professional is also very important and ought to be respected too. Kant considers freedom an important human quality and only permits restricting it where it is essential to protect freedom and possible to do so (Khan, 2005). Besides, health care professionals are free to choose careers outside health care or specialisations that do not require them to perform termination of pregnancies. They are not coerced into taking up these positions of privilege in society (Fiala & Arthur, 2014; K & Choice, 2013; Schuklenk & Smalling, 2017).

### 2.2.4 I will maintain the maximum respect for human life

The word respect here is used as a noun which means having deep feelings of admiration for someone or something elicited by their achievement, qualities or abilities. This is the view held by Immanuel Kant when he says that human beings

have intrinsic worth or dignity that makes them valuable beyond all price. Kant presents two reasons for this – first that humans have desires and things that can satisfy these desires have no intrinsic value -- their value lies only in that they can satisfy these human desires. Animals on the other hand are too primitive to have self-conscious desires. The second reason Kant gives is that human beings have intrinsic value because they are rational beings capable of making decisions, setting goals and guiding their conduct by reason to achieve these goals (Rachels & Rachels, 2012 p.137).

The moral principle derived from respect for human life is one of Immanuel Kant's famous formulation of the categorical imperative known as the formula for humanity:

> *Act so that you treat humanity, whether in your own person or in another always as end and never as a means to an end.* (Kant, 2013)

To treat people as an end never as a means to an end means treating them well, i.e. furthering their goals as far as we can, avoid harming them and respecting their rights. Refusal to treat based on personal religious and "moral beliefs" goes against the formula for humanity, as it uses the patient as a means to fulfil the religious beliefs of the objector. In addition, conscientious objection does not further the aims of termination of pregnancy seekers' goals; it does not respect their right (in this case their legal right to reproductive services or the moral right of autonomy over their bodies), and it simply does not care about their welfare.

It is perhaps important here to highlight an example used by Kant to illustrate what he meant by using other rational human beings as a means to an end rather than an end. His example had to do with borrowing money from a friend with no intention of paying back. This is important in this section of promise keeping – where health care

professionals are trained at the expense of the state and take an oath promising to dedicate their lives to the service of humanity, to have the utmost respect for human life, to respect patient autonomy, all the while knowing they will not fulfil this promise based on personal religious beliefs. This is what Kant will refer to as manipulating and using other human beings for our own ends and it is morally unconscionable.

Some conscientious objectors interpret the pledge to have the utmost respect for human life to mean that all physical life is sacred and that biological life ought to be preserved at all cost, saying “Christianity has never ceased to emphasise the sanctity of human life and the value of the individual, even the humblest and lowliest, including the afflicted in mind and body” (Baranzke, 2012). Conscientious objectors derive a perfect duty (one which is owed at all times) not to take life; referring to termination of pregnancy as infanticide (Cherry, 2011, 2013).

Conscientious objectors further interpret Kant to say a woman who opts for termination of pregnancy is using the foetus (a human being) as a means to an end rather than an end. In this view, termination of pregnancy even in cases of imminent danger to the pregnant woman or severe deformity in the foetus is seen as morally wrong or unacceptable, because it violates the duty to preserve life. This is perhaps why 14% of conscientious objectors in the Western Cape (C. G. Ngwena, 2014) still refused to participate in a termination of pregnancy even in the face of imminent danger to the mother.

There is little merit in this line of thought for several reasons. First, there is no consensus that sanctity of human life is a bioethical principle. There is nothing intrinsic in physical life as far as we know that makes it sacred apart from say the Christian belief that “man is created in the image of God”. Saying there is nothing intrinsic in

human life that makes it sacred does not mean that it is morally justifiable to take away human life. All I mean by this is that the “personal religious” justification contained in conscientious objection is inadequate to claim that there is something about human life that makes it morally wrong to terminate a pregnancy even in cases of deformity such as spinal bifida which will result in no quality of life to talk of. Secondly, what Kant meant by treating humanity as an end and not a means to an end -- which is contained in the pledge to treat life with the utmost respect -- has to do with moral actions and a virtuous character rather than a physical property of biological life (Baranzke, 2012). Treating human life with the utmost respect according to Kant is to “promote the welfare of others, respect their rights, avoid harming them and generally endeavour as far as we can, to further the ends of others” (Rachels & Rachels, 2012 p.138). The well-being of the prospective mother and her family and their ends and the fact that a foetus has no discernible ends to promote are issues beyond the scope of this research report. Nevertheless, it can be successfully argued that a healthy foetus at thirty-four weeks has certain rights that should be respected and that health care professionals should promote their well-being. This argument from biological differences between a four weeks foetus and thirty-four weeks foetus is in most legal systems (including South Africa’s), that allow termination of pregnancy up to 12 weeks and in some cases beyond 12 weeks. Such an argument will be based on sound moral reasoning not personal religious and moral beliefs as contained in conscientious objection which more often than not ignores the quality of life in its entirety focusing only on some abstract intrinsic quality in human life. This is morally unsound because the basic definition of morality requires that a range of factors are considered as reasons for action. Here, conscientious objection ignores certain biological facts, such as the fact that a foetus with spinal bifida would have a very poor quality of life.

### 2.2.5 I will not permit considerations of age, disease or disability, creed or ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other consideration to interfere between my duty and my patient

Having established the duties of care (beneficence), to dedicate life to the service of humanity, to have the utmost respect for life, to respect autonomy, the health care professional further pledges that she will not allow any other consideration to come between her duty and her patient. In essence, patient-centred care will consider nothing other than the patient and her well-being. Kant will call this a perfect duty – because it to be done at all times - to omit all other considerations such as social standing, race, gender etc. An act is morally right if it does not place other consideration to come between the physician and her duty to care for the patient.

Conscientious objection places the personal religious beliefs of the objector ahead of the health and well-being of the patient. In this regard, conscientious objection is morally unacceptable because it violates the moral rule that the health care professional ought not to allow other considerations to come between her and the patient. It is unconscionable to place the healthcare professional's subjective moral judgements ahead of the health and well-being of the patient.

### 2.2.6 Other duties from medical oaths

There are other duties derived from the medical oath such as respect for confidentiality, fostering the noble traditions of medicine, to practice with conscience and dignity and in accordance with good medical practice etc. These are not listed and expounded upon because the five highlighted above clearly demonstrate that

conscientious objection contradicts the pledge that all health care professionals make. I have shown that health care professionals have a duty to care for all human beings without exception and that conscientious objection violates this moral rule because it chooses not to serve some human beings. There is a duty to place the health and well-being of the patient above all other considerations which conscientious object violates by placing personal religious beliefs ahead of the medical presentation. More importantly, health care professionals voluntarily accept these duties by making the pledge. To break their oath is to act immorally and this is unconscionable.

### 2.2.7 The duty not to conscientiously object to termination of pregnancy

I have demonstrated that conscientious objection to the termination of pregnancy runs counter to duties established in medical oaths. But the question remains whether conscientious objection in itself is morally wrong rather than that it simply runs contrary to these voluntarily acquired duties. I will now use Kant's first formulation of the categorical imperative to show that conscientious objection to the termination of pregnancy is morally wrong and that health care professionals therefore have a duty not to conscientiously object.

The categorical imperative states "act as if the maxim of your action were to become by your will a universal law of nature" (Kant, 2013 p.493). Using this principle, Kant argues that moral agents have a duty not to perform acts that cannot be universalised without destroying the very nature of the act. Kant derives a perfect negative duty (an act we ought to refrain from doing at all times) for false promising by using the categorical imperative. We cannot universalise false promising for example without destroying the very nature of promise. Therefore, we ought to always refrain from false promising.

Health care professionals have a duty not to conscientiously object to termination of pregnancy services because such an act cannot be universalised without destroying its very nature. Conscientious objection really means the ability to cite personal religious and moral beliefs as a reason not to provide professional and legal services. Universalising this maxim means every health care professional or any professional for that matter can cite their personal religious and moral beliefs as reason not to perform their professional duties. This maxim allows farmers for example to cite their personal religious beliefs as a reason not to sell produce to people of a particular religion or ethnic group or sexual orientation. This is not only a contradiction of "conscientious objection" but also of the nature of what it means to be a health care professional or a professional. No society finds it moral to allow such discrimination from a farmer or a cobbler. Universalised conscientious objection on the basis of personal "moral" and religious beliefs destroys the ability of the health care profession to bring relief to the suffering and promote their well-being. It takes away much needed skills. Moreover, as I explain later in this report, it overburdens those who honour their moral duty to provide such services, leading to burnout and people leaving the profession.

It is perhaps important to note here that the Declaration of Geneva contains a pledge to foster the honour and noble traditions of the medical profession. Conscientious objection brings into disrepute the honour of the profession by requiring a pledge but permitting non-adhering to it. Also as mentioned above and discussed later in this report, an increased workload for colleagues who do not conscientiously object takes a toll on the entire system. The duty not to conscientiously object is similar to the duty not to deprive others of what belongs to them. Conscientious objection deprives medical practice of its good reputation by not keeping the profession's pledge and

society viewing the profession negatively because of this. Health care professionals motivated by their duty towards the honour and noble traditions of the medical profession ought not to conscientiously object to reproductive health services.

## 2.3 Conclusion

The primary objective of this chapter was to show that conscientious objection to termination of pregnancy runs contrary to a health care professional's oath. Using the Declaration of Geneva which contains age-old bioethical principles, I identified duties or obligations of a health care professional and showed that conscientious objection in principle runs contrary to these principles. For example, a health care professional has the ethical duty to treat all human beings equally without discrimination. However, the right to cite personal religious beliefs as a reason not to perform this duty means health care professionals can exclude some human beings from their duties. Based on this, I draw the conclusion that conscientious objection is not moral because it allows health workers to fail to perform their professional duties and more importantly, it breaks promises which should be kept according to Kantian morality. Conscientious objection is therefore in my view unconscionable.

I have also demonstrated that health care professionals have a duty not to conscientiously object based on the first formulation of Immanuel Kant's categorical imperative. This is because conscientious objection cannot be universalised without taking away from the profession. Kant calls the type of duty that prohibits action at all times a perfect duty.

Finally, I have answered the counterargument that there may be circumstances where refusal to provide termination of pregnancy services is moral and permissible. Such cases will have adequate moral justification in normative moral theories such as Kant's

formula for humanity. These cases cannot be justified on the basis of personal religious beliefs that claim sanctity of life. My conclusion is that there are no cases where termination of pregnancy can be refused based on conscientious objection and as such conscientious objection is always morally wrong and unconscionable.

The last remark to make in this chapter is the criticism of Kantian ethics that says rules are not absolute and can often conflict with each other. Rachels and Rachels (2012 p.131) uses the case of the inquiring murderer to illustrate that the rule not to lie may conflict with the rule to preserve life. Rule-based ethics appears not to be sufficient to satisfy real life situations where duties to one's self and duties to others may conflict. However, as I hope I have shown in this chapter, Kantian rule-based ethics is very good at identifying the duties of a moral agent. Virtue ethics, the subject of the next chapter is better placed to address issues of conflicts between rules by focusing on the character of the health care professional.

# 3. Virtue Theory and Conscientious Objection

## 3.1 Introduction and Basic concepts

In this chapter, I will argue that in terms of virtue ethics conscientious objection to the termination of pregnancy runs contrary to certain ethical virtues and claim that if actions are the best interpreters of character, reports in South Africa show that those who conscientiously object to termination of pregnancy display behaviour that is not consistent with a virtuous character. I must admit from the outset that a virtuous health care professional having considered all factors related to a particular case may choose to terminate or not to terminate a pregnancy, but this will be based on sound virtue ethics reasoning and not on personal religious and moral beliefs.

In order to make my arguments in this chapter, I need to clarify some key concepts:

- Virtue ethics
- Virtue
- Practical wisdom

### 3.1.1 Virtue Ethics

It has been written that the term “virtue ethics”, which was introduced in the 1960s is a normative approach to ethics which is centred around the character of the moral agent (Gottlieb, 2009). Derived from the philosophy of Aristotle, virtue ethics emphasises “being” good rather than “doing” good. Whereas Kantian deontology (introduced in the previous chapter) focuses on duties and goodness of motives, virtue ethics is concerned with goodness of character. Virtue ethics also considers moral action as one with good motives and morally bad action as one with insufficient motivation to do the right thing (Bain, 2018).

In terms of morality, the basic framework of virtue ethics or virtue theory holds that “an action is morally right if it is what a virtuous agent would typically do in the same circumstances” (Hursthouse, 1991a). Although this does not tell us much about who a virtuous agent is, it is obvious that not only the act itself or its consequences need to be considered. The circumstances under which an act takes place and the character of the moral agent are very important in the virtue ethics approach to moral decision making. This contrasts with Kantian deontology where general rules and duties such as “never lie in any circumstances for it is not universalisable” can be determined by the theory *a priori*. Hursthouse goes on to say that a virtuous agent is one who acts virtuously and who has and practices the virtues. In medical practice, a virtuous health care professional is one who has and exercises the relevant virtues. Hurwitz and Richardson (1997) suggests that “t*he main intention of medical oaths seems to be to declare the core values of the profession and to engender and strengthen the necessary resolve in doctors to exemplify professional integrity, including moral virtues such as compassion and honesty*”. In order words, the health care professional ought to practice the virtues of compassion and honesty.

### 3.1.2 Virtue

Hursthouse and Pettigrove (2018) describe a virtue as an excellent trait of character well rooted its possessor. Possessing a virtue is not similar to having a habit like always taking the stairs, because this can be done with little or no reflection. Possessing a virtue means to notice the circumstances, expect certain outcomes, have certain feelings, reason out and choose certain actions and react in a characteristic way. As the Hursthouse and Pettigrove (2018) put it, a virtuous agent has a complex mind set which wholeheartedly accepts a distinctive range of considerations as reasons to take or not to take certain actions. Having the virtue of

honesty does not merely mean that the agent thinks honesty is the best policy or fear being caught out in a lie; rather, it is the recognition through reflection (motivation) that to act differently would be dishonest. An agent who possess the virtue of honesty, reasons about and gives due respect to honesty in every circumstance, without unreflectively using honesty as a mere rule.

It is said by Hursthouse and Pettigrove (2018) that having a virtue is a matter of degree and that it is rare to find a moral agent who has perfect virtues. Aristotle distinguishes between having full virtue and the concept of continence whereby a moral agent still manages to act virtuously despite an inclination to act differently (Stohr, 2003). Overcoming inclination and difficult circumstances to act virtuously it what makes a virtuous character. The virtue ethics approach to morality does not have exemplary virtuous agents like Aristotle whose character can be copied in similar circumstances (similar to the Christian "*what would Jesus do*?" bracelets). The virtue ethics approach understands that two virtuous agents under similar circumstances upon reflection may come to different courses of action.

### 3.1.3 Practical Wisdom

Virtue ethics distinguishes between having a virtue and having the practical wisdom or *phronesis* to act virtuously. Hursthouse and Pettigrove (2018), point out that a virtue such as courage in a desperado could push her to do cruel things and compassion can lead another to be dishonest in order to avoid hurting the feelings of others. Simply possessing a virtue does not mean one will act in a morally acceptable way. Practical wisdom (phronesis) that comes with experience gives human beings the rational discipline to guide the virtues and to enable its possessor live well. Living well according to Aristotle means fulfilling our function or essence just like knives and forks

have a function (Pojman & Fieser, 2012). In other words, the practice of virtues allows the agent to flourish or achieve her potential. Human flourishing or fulfilling human potential according to virtue theory is achieved through the practice or application of virtues such as compassion, trustworthiness, integrity, discernment, kindness, honesty, and conscientiousness (Gardiner, 2003; Karen Koch & Menezes, 2015).

Having provided some background information on the key concepts in this chapter, I now turn my attention to the views of virtue ethics on voluntary termination of pregnancy. I conclude that since virtue ethics focuses on the character of moral agent and a full analysis of each case, it is not possible to provide a clear-cut answer to the question to conscientiously object or not to conscientiously object. Even when it is medically indicated or situationally complicated by rape; virtue ethics still holds that to terminate the life of a foetus is morally complex.

## 3.2 Termination of Pregnancy is an Irresolvable Moral Dilemma

In this section, I introduce the concept of an irresolvable moral dilemma. I make the argument that termination of pregnancy in general is an irresolvable moral dilemma that does not lend itself to simple yes or no answers. Virtues ethics in focusing on the development of a virtuous character, does not provide answers that will apply to every termination of pregnancy request.

Unlike deontology or other normative ethical theories that follow rules to provide clear cut moral guides to action, the virtue ethics approach to medical termination of pregnancy is more nuanced. Hursthouse quoted in (Gottlieb, 2009 p 119) describes what she calls an “irresolvable moral dilemma”. She defines it as a situation whereby an agent has to do either x or y but both are equally wrong; or a situation where two

moral requirements conflict but none overrides the other. This will appear to be the case with voluntary termination of pregnancy in general and particularly with termination of pregnancy in rape cases. This is so because a truly virtuous agent will find it difficult to terminate a healthy pregnancy but on the other hand will also have compassion for a young rape victim. It is definitely not easy to choose *x* (allow a woman with little prospects to perform fully the duties of a mother when she is about to have a seriously deformed child) over *y* (terminate the pregnancy and give the woman a chance to develop herself). In real life situations, Hursthouse argues that forced to follow one course of action, for example to refuse termination of pregnancy services or to provide them, a virtuous agent may suffer feelings of distress, regret, remorse or guilt; or in some cases recognise that an apology or restitution or compensation is required. This regret or remorse or the new requirement for an apology is called moral "*remainder*" or "*residue*". It is unlikely that remainder is going to contribute to the good life or human flourishing (harmony of the soul) (Pojman & Fieser, 2012 p 57 - 58).

The moral dilemma involving conscientious objection to termination of pregnancy and/or conscientious objection is not that one option is virtuous and the other vicious. Either one will leave a virtuous agent with residue and as virtue is a matter of degree; it may also be that residue is a matter of degree. If this is the case, it may be that one option leaves more residue than the other or that one option is slightly more virtuous than the other. Nonetheless, certain virtues as we will see below appear to be less compatible with conscientious objection and in practice objectors exhibit vicious behaviour.

## 3.3 Conscientious objection is not virtuous

In preceding section, I introduced the concept of an irresolvable moral dilemma and argued that voluntary termination of pregnancy whether medically indicated or motivated by social factors is an irresolvable moral dilemma. In this section, I argue that conscientious objection in reproductive health attempts to solve an irresolvable moral dilemma. It does so by following a rule derived from personal religious or moral beliefs. Conscientious objection is not moral according to virtue ethics because it is bound to leave a virtuous agent with remainder.

What has virtue ethics got to say about the question whether "to conscientiously object to termination of pregnancy or not to conscientiously object?" Would a virtuous agent cite personal religious and moral beliefs as a reason to refuse medical assistance in any case including termination of pregnancy? Virtue ethics may view personal religious and moral beliefs as part of the motives that form a person's character. These beliefs may be included in the wide range of considerations used by virtuous agents to arrive at moral decisions. However, religious beliefs cannot not be the overriding consideration. In choosing only one consideration over many conscientious objection shows itself not to be virtuous because it does not consider a range factors as reasons to refuse termination of pregnancy. In addition, a virtuous agent in the face of moral dilemma will take a different course (choose either x or y) given different circumstances. In a case of say a 12 weeks foetus with spina bifida, a virtuous agent may offer termination of pregnancy. Whereas in the case of a 32 weeks healthy foetus, a virtuous agent may refuse to offer such services. Given that termination of pregnancy is an irresolvable moral dilemma, both options are bound to always leave residue. The fact that conscientious objection does not consider different circumstances and always chooses the same option makes it not virtuous as already stated. Conscientious

objection also appears not to leave any residue as objectors normally show no regret when women face serious difficulties with unwanted babies.

The core motives of conscientious objection to refuse treatment centre around the personhood of the foetus and the right of a woman over her body. Virtue theory does have something to say about these two issues to which I now turn my attention to.

### 3.3.1 Personhood of the Foetus

Hursthouse (1991) notes that the question on the personhood of foetus is a metaphysical one which cannot be answered easily by any moral theory. But a clear answer is required since in order to act virtuously, we ought to have accurate and reliable knowledge. An agent cannot have the right and correct attitude to something if the attitude is based on or involves false beliefs. The foetus may or may not be a person at conception as is often claimed by conscientious objectors. We do not have accurate and reliable knowledge on the personhood of the foetus. But even if we accept that a foetus is a person, we could still act virtuously in terminating a pregnancy or selfishly, self-righteously, stupidly, inconsiderately, or dishonestly – in other words viciously - when we conscientiously object to termination. The idea is to be motivated by virtue rather than by the “personhood” of the foetus of whom we do not have very good information.

Following a rule on the personhood of the foetus ignores the many different circumstances in which it may be virtuous to terminate a pregnancy rather than carry to full term. Chervenak, McCullough, and Campbell (1999) argue that a health care professional ought to be sympathetic with a woman and her unborn child who both have achondroplasia (dwarfism) even in the third trimester if through her own experience of living with dwarfism and acting out of sympathy for the well-being of the

child, she opts for a termination of pregnancy. Focusing on only on the personhood of the foetus ignores all the other factors required for human flourishing, including residue which may affect a virtuous health care professional. According to Eudemonist virtue ethics, the health care professional flourishes when what she wants to do and what she ought to do (i.e. consider a range of factors as reasons for action) are in unison. In not considering factors including residue for herself, the conscientious objector does not act virtuously.

In South Africa, many may opt for a voluntary termination as they perhaps have too many children they can ill afford or they are emotionally not ready for motherhood or they do not have the family structure to support another child. It is vicious not virtuous in almost all circumstances to prolong the life of a suffering “person” whether it is physical or psychological suffering. There may be circumstances where there are enough resources to look after such suffering or where there are no medical reasons for termination. In such circumstances, a pregnancy termination could be the vicious option both for the expectant mother and the health care professional. In such circumstances, the motivation of compassion or sympathy for both unborn and mother and not the excuse of personal religious beliefs supports the case for treatment refusal. The important point is that a wide range of considerations should be taken into account not only the belief that the foetus is a person, which may or may not be false.

To further illustrate the point of physical suffering where termination of pregnancy is the best option, I present the case of neural tube defects. In South Africa the country with the highest number of people living with the Human Immunodeficiency Virus (HIV) (Price et al., 2019), children born with HIV are often abandoned. These children can lead normal successful lives, as HIV treatment is excellent these days. However, it has recently been discovered that one of the most effective drugs against HIV

Dolutegravir may cause neural tube defects such as anencephaly (born without parts of the brain) and spina bifida (poorly formed spine) in the developing foetus (Aschenbrenner, 2019). These developmental birth effects may result in very poor quality of life. It may also be the case that mother of the child does not have the means to look after a child with anencephaly. A lack of sympathy for the well-being of the mother and foetus causes conscientious objection to ignore these factors. Sympathy here is used in the sense used by David Hume. That is the capacity to receive by communication the inclination and sentiments of others however contrary or different from our own (Wand, 1955). It is vicious not virtuous to allow a child to be born without a brain knowing that their short existence may be just one of pain and suffering.

### 3.3.2 Virtues Ethics and a Woman's Right to her body

Conscientious objectors argue that a woman has no moral right to her body to voluntarily choose to terminate a pregnancy. The pro-choice position on termination of pregnancy is that a woman indeed has a moral right over her body. Further arguing even if the personhood of the foetus is granted, it is the right of the woman to decide whether to have another person attached to her body for approximately nine months. This metaphysical question on the moral right of the woman cannot be easily resolved either way.

However, virtue ethics does not require a resolution of the moral right issue to take a position on termination of pregnancy or conscientious objection. It is the motivation to act in one way or the other that expresses virtue or vice. Virtue ethics takes the position that the moral right to one's body can be exercised in in a selfish, dishonest, inconsiderate manner (Hursthouse, 1991a). Decisions and actions on termination of pregnancy can be either virtuous or vicious irrespective of whether a woman has a

moral right over her body. As discussed above under the personhood of the foetus, the decision to terminate a pregnancy with a malformed baby can be compassionate taken with sympathy towards the difficult life the mother and the child are bound to have. On the other hand, women who choose to terminate a pregnancy for no other reason than that they are not ready for motherhood or want to continue "enjoying" their lives may be acting viciously. In deciding, the course of action to take, a virtuous health care professional ought to consider a range of factors including whether the expectant mother is acting virtuously or viciously.

The real issue that virtue ethics has with citing personal religious and moral beliefs is that religious beliefs are not virtues. Morality requires a moral agent to select the best reasons for action or inaction. Personal religious and moral beliefs are not valid virtues. A virtuous moral agent responds with character traits such as sympathy and compassion rather than with an excuse such as "my religion says women do not have a right over their bodies, therefore they cannot choose to terminate a pregnancy". These virtues of sympathy, compassion, honesty kindness etc. are essential for human flourishing, especially in South Africa where some of these virtues are lacking in many spheres of society.

## 3.4 Virtues Missing in Conscientious Objection

In this section I focus on two core virtues relevant to medical practice and show how these may be lacking in conscientious objection.

Many virtues such as kindness, compassion, honesty, teamwork, fairness, empathy, sympathy, judgment etc. have been identified as being important in medical practice (Kotzee, Ignatowicz, & Thomas, 2017). The aim here is not to list virtues but to show

as I have done above with sympathy, how relevant some virtues are to the question of conscientious objection to termination of pregnancy.

In this report, I limit myself to the virtues of honesty and compassion firstly, because it is a lot easier to show how these virtues are relevant to flourishing and how lack thereof in the case of conscientious objection limits human flourishing. Also, by selecting these virtues, I can counter one or two of the arguments advanced for the protection of conscientious objection. A kind health care professional would hardly be a hypocrite who is dishonest in order to avoid extra work. A compassionate health care professional would also be team player. This is perhaps what Aristotle meant by unity of the virtues – that is, it is impossible to have one virtue fully without others (Gottlieb, 2009 p192).

### 3.4.1 Honesty

Honesty as a moral virtue is the cornerstone of all human relationships especially the doctor-patient relationship. It is key to the "good life" (flourishing) when we engage with others such as family, fellow citizens and colleagues. Virtue theory holds that an honest health care professional is not only one who habitually tells her patients the truth as she sees it. A virtuous health care professional practices honesty when they reflect on different choices always with the view of avoiding dishonesty and deception, choosing honesty and truth (Hursthouse & Pettigrove, 2018). Moral or professional integrity is linked to honesty to the extent that the behaviour of a moral agent is consistent with their stated values. In other words, their character and their actions are consistent with the beliefs, values and principles they claim to hold. To act differently and not try to avoid dishonesty or deception, is morally wrong.

Conscientious objectors do not deny the core values of medicine to bring relief to the suffering. As seen in chapter 2 above, all health care professionals swear an oath to place the well-being of the patient above all. Conscientious objection in principle is not consistent with the values of medicine and as such is not honest. Objectors promise to keep the core values of medicine in the Pledge knowing they will not. They join the profession knowing it is a duty to care for the suffering but intend not to care for all suffering people. In addition, it is impossible to determine whether a person truly believes in the values they express. Their actions are the best reflection of their core beliefs. As has been shown by (Harries et al., 2014, 2009) conscientious objectors are often dishonest, refusing to perform termination of pregnancy in the public service while doing so for a financial incentive or time off work. Even if all objectors display behaviour consistent with their stated personal religious and moral beliefs, this would still not be consistent with the values of medicine they have sworn to uphold. Behaviour that is inconsistent with professional duties and values of medicine is essentially dishonest.

A strong case has been made for conscientious objection based on the fact that allowing conscientious objection preserves the moral integrity of the objector (Schuklenk & Smalling, 2017; Wicclair, 2017). This is a case for the moral virtue of honesty; for to act against one's beliefs would be dishonest. Wicclair, who claims that allowing for conscientious objection on the basis of moral integrity is one of the strongest reasons to allow conscientious objection, also points out that other factors such as the health and well-being of the patient and considerations for colleagues trump the interest of the objector. So even granted that conscientious objection should be allowed in light of moral integrity, it should never be placed above the well-being of

the patient or the interest of overworked colleagues for to do so will be to act selfishly; or in the words of virtue theory, to act viciously.

Savulescu & Schuklenk (2017) argue that the moral integrity argument cannot be taken too seriously because we can never be sure that the objector truly holds the beliefs they claim to have. Since it is not possible to determine whether it is indeed "conscience" or other considerations that is the real reason behind the objector's actions, the onus ought to be on the objector to prove that her beliefs are indeed genuine. No such proof has been documented in South Africa for conscientious objectors, prompting a nurse to say she often feels like asking the objector for their "written excuse" (Harries, Cooper, Strebel, & Colvin, 2014). On the contrary, there is ample evidence in the South African medical literature that suggests conscientious objectors for some incentive or another would perform termination of pregnancy services. This of course is morally dishonest. One article states that a Catholic health care professional who offers termination of pregnancy services claimed to be able to separate her professional duties from her religious faith (Harries, Stinson, & Orner, 2009). Perhaps all objectors who want the right to cite their personal religious beliefs as a reason to refuse professional services should do the same, separate their faith from their professional duties. That is, align their actions to the ethical values of the profession. In the view of virtue theory, these values include honesty.

### 3.4.2 Compassion

Compassion has been defined as "an active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness and discomfort at another's misfortune or suffering" (Gardiner, 2003). Put differently, a sensitivity to the suffering of self and others with a strong commitment to work towards

removing the suffering or preventing it altogether (Fotaki, 2015). The best definition for compassion identifies the word with its etymological roots as “suffering with” – compassion is a profound awareness of the suffering of another coupled with a desire to correct the suffering (Sinclair et al., 2016). Gardiner (2003), Fotaki (2015), Sinclair et al. (2016) and others such as (Gelhaus, 2013) suggest that compassion should be the foundation of medical ethics as it embodies the ethos of medical practice. According to virtue theory, compassion is not about acting compassionately sometimes, but it is rather having a mind-set consistently attuned the suffering of others, and considering a wide range of factors as reasons to take action to remove the suffering. Virtue theory requires that in addition to the virtues, health care professionals have the practical wisdom to apply compassion in a virtuous instead of a vicious manner in a manner that allows human flourishing – allows all concerned to reach their full potential.

Compassion is especially important in the uniquely emotionally charged state of pregnancy and of course the difficulties that may bring about the question to terminate the pregnancy or not. My claim that conscientious objection to termination of pregnancy in South Africa lacks compassion is supported by the literature shows that many objectors do not display this virtue (Harries et al., 2014, 2009; Teffo & Rispel, 2017).

It is not only the suffering of termination of pregnancy seekers that conscientious objectors seem oblivious to. It would seem most lack sympathetic feelings towards their colleagues who offer these services, sympathy being a vital component of compassion (Gelhaus, 2012). Several authors in South Africa document the suffering of health care professionals working in clinics and hospitals that offer termination of pregnancy (Haffejee et al., 2017; Harries et al., 2014, 2009; Lince-Deroche et al.,

2017; Teffo and Rispel, 2017). In Italy where more than 70% of gynaecologist are conscientious objectors, a study found an increased workload of non-objectors and longer waiting periods to access termination of pregnancy services (Bo, Zotti, & Charrier, 2015). The longer waiting periods are very important given that termination of pregnancy is mostly legal within the first twelve weeks. In South Africa, Teffo and Rispel found conscientious objectors (including administrative staff) act more like "conscientious obstructers" in order to delay providing services beyond the legal 12 weeks. This behaviour is not consistent with compassionate care.

In addition to an increased workload, termination of pregnancy service providers often suffer social stigma being called names such "baby killers, murderers" etc. by objectors. It would seem that conscientious objectors' behaviour towards their colleagues is the exact opposite of compassion. It may be that this argument is against the behaviour of those claiming conscientious objection and not conscientious objection itself. However, virtue ethics focuses on the character of a moral agent. This behaviour is inconsistent with a virtuous character – and we have shown that citing personal religious beliefs as a reason to refuse professional services is not virtuous. It is not virtuous because it refuses to recognise the suffering of others and more importantly refuses to suffer with the other in a spirit to alleviate the suffering.

Kotzee et. al. 2017 identified teamwork as value that health care professionals recognize as important in the practice of medicine. Conscientious objectors, if they are honest, ought not only to be sympathetic towards vulnerable children seeking their services but also to understand the suffering of their colleagues and to respond to it more compassionately than is currently the case. Their actions in light of the suffering of their colleagues can only be viewed as vicious not virtuous.

The lack of sensitivity displayed by conscientious objectors to the pain of their colleagues is perhaps minimal in the face of the enormous suffering by women seeking the legal medical services which only they are competent to provide. Unintended pregnancies are generally highest amongst the unemployed and those with a low income. Unwanted pregnancies strongly correlate with being single and unemployed (Haffejee et al., 2018). The chances of these women and the children they bring to life living the “good life” or flourishing are very small. The statistics of women showing up in hospital with incomplete terminations (Rees et al., 1997) some due to backstreet operations are grim. The abandonment of new born babies is a regular occurrence in major cities in South Africa (Grimes et al., 2006; Jewkes et al., 2005). In the face of this suffering, my argument is that the so called “conscientious” objector is not acting compassionately when they refuse treatment. A health care professional who is sensitive to the suffering of these women would at least consider other factors before turning them away. The kind of desperation that will lead a young woman to risks her life with a backstreet termination should concern all human beings, especially those with the requisite skill set to help. To turn a blind eye to this kind of suffering in the name of conscientious objection is to have concern only for oneself. In order words, it is to act selfishly.

Conscientious objectors consider only one factor – their personal religious and moral beliefs – as a reason for inaction. Compassion allows the consideration of various factors. In some cases, it may be more compassionate to terminate the pregnancy even in late term of a malformed foetus who would end up with a vegetative suffering life. In other cases, it is more compassionate to cause the foetus to be carried to full term by refusing an abortion. In both cases, the motivation is compassion and not personal religious and moral views.

## 3.5 Conclusion

In this section, I have shown that although virtue ethics does not completely exclude treatment refusal with regards to termination of pregnancy services, virtue ethics cannot be used to justify conscientious objection. Citing personal religious and moral beliefs as a reason to refuse treatment is not moral. Generally speaking, conscientious objection proceeds from the vice of selfishness; i.e. it places the “personal” religious and moral beliefs of the health care professional ahead of the well-being of both patients, foetus and mother. A virtuous health care professional does not limit herself to only one consideration as is the case with conscientious objection. Conscientious objection follows one deontological rule -- to preserve the life of the foetus irrespective of the quality of life the child and mother will have. More importantly, health care professionals in South Africa seem oblivious to the vast socioeconomic disparities in society. They lack sympathy in the sense that David Hume described.

To further show that conscientious objection is unethical, I considered the virtues of honesty and compassion. I have argued here that conscientious objection especially as it is practiced in South Africa, is dishonest. First in that it is not consistent with the professional values objectors have sworn to uphold. Secondly, in practice it means abandoning their professional duties.

I have also demonstrated that conscientious objection is not compassionate in the face of suffering brought about by unwanted pregnancies. The argument is not that all unwanted pregnancies should be terminated. Rather than each case should be judged by its merits and action or inaction taken based on compassion, responding to the specific suffering in each case. Health care professionals act viciously when they do nothing to alleviate human suffering. Compassion is linked to the virtues of empathy

and sympathy as well as active care. Without sympathy (suffering with) or empathy (feeling inside the suffering of the patient), health care professionals cannot actively respond with care or kindness.

Perhaps, it may be argued that I have selected only virtues that make the case against conscientious objection. This is not so, because I have demonstrated that citing personal religious beliefs as a reason to refuse treatment is inconsistent with virtue ethics in general. It may be argued that standing up for one's "moral" convictions in a society that accepts termination of pregnancy is expressing the virtue of courage. If this is the case, this courage is being expressed in a callous (vicious) manner that ignores the suffering that is attendant in some of the cases discussed above. Many young women resort to backstreet terminations when they have been refused professional services that are both ethical and legal in the medical profession. It is also not true that termination of pregnancy is widely accepted in South Africa. The stigma associated with termination of pregnancy and the fear that pushes young women to backstreet procedures is testament to this. It would seem more like cowardice in the face of what is an enormous health hazard to claim conscientious objection and refuse to help. Whichever virtue one choses to apply to the question of refusal to treat, the bottom line is that conscientious objection does not contribute to flourishing. Conscientious objection in general is vicious not virtuous.

# 4. Principlism

## 4.1 Introduction and Basic Concepts

Principlism as a system of ethics is very recent. Principlism only came on to the scene in the latter part of the 20th century (Serna, 2016). It originated in the work of the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The commission was formed in part due to issues arising out of the unethical Tuskegee clinical trial. This infamous trial conducted by the US Public Service from 1932 – 1972 aimed to study the natural history of syphilis (Schmidt, 2003). The researchers failed to treat study participants even when penicillin was known to be an effective cure for the syphilis[1].

Beauchamp and Childress in their book *Principles of Biomedical Ethics* first published in 1979 applied the four principles which were mainly for clinical research to other fields in health care. Their stated aim was to augment normative moral theory in medicine which was mainly focused on a "beneficence and care model" with the principle of autonomy and wider concerns of social justice (Gillon, 2015). These principles: respect for autonomy, beneficence, non-maleficence and justice are abstract moral statements of obligation that are easily understood by professionals from different fields. The work of Beauchamp and Childress is therefore rightly considered as principlism in ethics.

[1] Although the researchers do not cite personal religious beliefs as a reason to withhold professional services; the refusal to treat was not motivated or justified moral reasoning. It could only be some personal "moral" or religious belief and as such the refusal to treat is similar to conscientious objection.

The four principles framework is the dominant approach to the teaching and evaluation of ethical dilemmas in biomedical ethics (Page, 2012). It has been claimed that these principles which can be viewed as the four moral nucleotides that make up moral DNA and that the principles can individually or together explain or justify all substantive and universalisable moral norms of health care ethics (Gillon, 2003). Of course, there are criticisms of the principlism approach including the fact that the principles are simplistic; that the approach overemphasises autonomy and the difficulty of resolving issues when the principles conflict. Despite the critique, the principles are useful as a tool for resolving moral dilemmas. It has to be admitted that though they are widespread in bioethics and cannot be easily ignored, practical judgements cannot be easily derived from these principles.

Beauchamp argues in the book by Serna (2016) that the principles are best applied together. Some of the principles can be justifiably superseded by the moral norms which they come into conflict with. For the purposes of this report, I will focus on autonomy, non-maleficence and justice. This is not because I have chosen to ignore beneficence. However, the need for health care professionals in South Africa to act beneficently in case of termination of pregnancy has been sufficiently justified in the preceding chapters particular in the section on virtues.

I will argue that taken together, these principles support my core argument that conscientious objection to termination of pregnancy in South Africa is morally wrong.

### 4.2 Respect for Autonomy

In this section, I present my understanding of the principle of respect for autonomy in the medical context and then make ethical and legal arguments that a woman's

autonomy over her body ought to be respected by health care professionals especially in the case of termination of pregnancy.

The concept of personal autonomy which is central in Western medicine and medical ethics has been defined as “self-rule” (Varelius, 2006), -- the ability or the right to make one’s own decisions free from controlling interferences by others or coercion. The principle of respect for autonomy encompasses two moral obligations. First, a positive obligation of respectful and appropriate informational exchanges that allows self-initiated intentional action. And secondly, a negative obligation on others not to subject the autonomous person to controlling constraints (Beauchamp, 2016). In addition, the principle of respect of autonomy contains the obligation to respect the confidentiality and privacy of patients (Entwistle, Carter, Cribb, & McCaffery, 2010). In medical ethics, or more specifically in the case of termination of pregnancy, respect for autonomy obligates the health care professional to disclose all appropriate information and to avoid manipulation of the service user to her own point of view i.e. personal religious and moral beliefs.

### 4.2.1 Autonomy as a Legal Right in South Africa

Section 12(2) of the South Africa constitution states that “*everyone has the right to bodily and psychological integrity which includes the right* (a) *to make decisions concerning reproduction*; (b) *to security and control over their body*” (South Africa, 1996). The progressive South African constitution is very explicit in its acceptance of the principle of respect of autonomy. It upholds the view that decisions on reproduction rests in the hands of women and that these should be free of psychological influences from others. The Choice of Termination Of Pregnancy Act reinforces the respect for autonomy when it sets out in article 2 the conditions under which a pregnancy may be

terminated. The “request” of termination of pregnancy by a woman is given pride of place in the act. It recognises and respects the agency of a woman to make an intentional autonomous decision to have a child or to terminate an unwanted pregnancy.

The constitutional right of a woman over her body should of course be counterbalanced with a health care professional’s constitutional right to freedom of conscience and religion. While I agree and support the right of health care professionals to believe in any religion and hold any views, I have taken the view that it is neither legal nor moral to cite personal religious and moral beliefs as a reason to withhold professional services, especially in cases which may involve life and death issues. Exercising freedom of conscience to allow a child to be born into a vegetative life or to allow a woman to die due to sepsis because of personal religious beliefs of a health care professional should not be permissible. It may be for argument sake that a cobbler is allowed to cite her religion in refusing to make shoes for people of a certain sexual orientation, but it should not be permissible for health care professionals to cite personal religious beliefs in matters involving life and death. Even in situations where there is no danger to the expectant mother and the foetus is healthy, practitioners should not be allowed to cite personal “moral” and religious beliefs as grounds to refuse termination of pregnancy. In such cases, there are sufficient ethical grounds to refuse termination without resorting to religious beliefs.

### 4.2.2 Autonomy is a natural and moral right

I will argue in this section that a woman’s autonomy over her body is a natural right that ought to be respected.

David Hume's philosophy makes a clear distinction between legal rights to one's property based on civil laws and the natural moral right to one's arms and limbs (Hursthouse, 1991b). Natural rights are those not derived from civil law but rather rights possessed due to nature. Aristotle for example argues that ethics can only be discussed by mature and experienced human beings (Finnis, 2011 p.31). The natural right to discuss ethics comes from experience and maturity which means age is naturally required for this right. Laws cannot give experience or maturity, these two can only be acquired naturally. In like manner, civil laws cannot grant anyone a body, having a body comes naturally. I argue here that women have a natural right over their bodies and to make autonomous decisions on how to use their bodies. Kantian ethics uses the categorical imperative to show why it is important to respect autonomy and make it a right (Willaschek, 2009) by demonstrating that coercion cannot be universalised. Kant holds that "*it is impossible to think of anything at all in the world, or indeed even beyond it, that could be considered good without limitation except a good will*" (Kant, 2013). According to Kant then, the free unforced will is the supreme good. Following on Kantian philosophy it is our duty to pursue a free will for all human beings based on his principles of universality. Conscientious objection removes a women's "will" from her hands and places it in the heads of the health care professional. In other words, it is paternalism.

Authentic respect of autonomy requires more than non-interference. It requires that action is taken to enhance autonomous decision making. In the case, of termination of pregnancy, it requires the health care professional to provide all information that is necessary to make the correct decision. It may be the case that some termination of pregnancy service seekers are not aware of their legal or moral right to terminate a

pregnancy. The health care professional is morally duty-bound to provide such information.

### 4.2.3 Autonomy of foetus and Health Care Professional

The question may arise that the autonomy of the foetus and that of the health care professional to make unforced decisions ought to be respected too. In this section, I argue that we do not know what the decisions of the foetus are, and a decision to remain attached to another person infringes on the autonomy of that person. In addition, freely taken autonomous decisions of the health care professional ought to be respected. I argue that decisions based on personal religious and moral beliefs are not free and should not be respected.

It is questionable that the foetus can be autonomous in morally relevant sense of self-rule through reason. There is no autonomy to talk of in case of the foetus though conscientious objectors may want to advance such an argument. It is recognised that children have limited autonomy to make their own decisions and therefore depend on their parents to for example consent to participate in a research study (Waligora, Różyńska, & Piasecki, 2016). Limited autonomy is related to the fact that children lack the rational faculties to make their own decisions. It follows then that foetuses cannot make and communicate autonomous decisions about their own health. In a case of a malformed foetus with spina bifida it does not make sense at all to talk about the autonomy of the foetus without a brain. Even adults with limited capacity to make decisions for themselves have this delegated to guardians. There is no point in talking about respect of autonomy when it comes to foetuses.

Health care professionals voluntarily take up the duties inherent in their jobs and are free to decide to quit at any time. Their autonomy to refuse to perform professional

duties ought to be accommodated as far as possible. However, I take the view that decisions based on personal religious and moral views are not autonomous. It may be an autonomous decision to be a Catholic or a Jehovah's Witness, but to refuse to perform a termination of pregnancy or blood transfusion is not. The decision that Catholics should not have a termination of pregnancy or participate in one existed before some Catholic health care workers were born. A health care professional may claim that they are free to make the choice to accept the tenets of their faith, but I argue that it is similar to having freedom of speech but not freedom to shout fire in a packed theatre. For that causes harm and, in this case, decisions based on religion cause harm.

### 4.3 Non-maleficence

*Primum non nocere* (above all do no harm or first do no harm)

In this section, I will outline what the principle of non-maleficence means, i.e. to not harm the interest of person. I will then show how conscientious objection harms the interest of pregnant women, society, and non-objecting health care professionals.

The principle of non-maleficence - thought to originate in the Latin maxim *"above all do no harm"* – obligates the health care professional to abstain from causing harm (Smith, 2005). Participants in a study measuring the importance of ethical principles including the four of principlism weighted non-maleficence as the most important ethical principle. Though when presented with ethical dilemmas, these participants did not show a preference for non-maleficence in resolving ethical dilemmas (Page, 2012). It is often thought that non-maleficence and beneficence are two sides of the same coin. However, one (beneficence) requires specific action while the other (non-maleficence) prohibits acting.

The type of action that non-maleficence prohibits may include torture which physically injures a person. Childress has written that “harm” in non-maleficence does not entail wrongfully injuring or maleficence. Harm is action or inaction that “thwarts, defeats, or sets back the interests of an individual whether caused deliberately or not (Beauchamp, 2016 p.6). Interest here does not merely mean something interesting or desirable to the individual but something that is in their interest. Interest as in the noun meaning something that gives an individual what is important to them or is necessary for their wellbeing or helps in some way. Parenthood in some cases is desirable but not necessarily in the interest of some. Children and some young teens may love playing “parents” but actual babies are not in their “interest”. So, when harm is considered as in what is in the interest of someone, we ought to consider both short- and long-term harm.

In this section, I will argue that conscientious objection based on the principle of non-maleficence is ethically wrong, first because in principle, conscientious objection thwarts, defeats or sets back the interests of women seeking a termination of pregnancy. Secondly, conscientious objection, thwarts, defeats or sets back the interest of the state or society.

### 4.3.1 Interests of the pregnant woman

Unintended and unplanned pregnancies may result in serious adverse health, economic, psychological and social outcomes especially for young women (Sedgh, 2016; Singh et al., 2010). The seriousness of the health outcomes can be underlined by such permanent conditions as death. It goes without saying that it was not in the interest of the young 19-year-old student who died in Johannesburg in 2016 (Amnesty International, 2017) to deny her a medical termination of pregnancy. She underwent

an illegal backstreet termination of pregnancy and died from the complications. Having shown that conscientious objection is unethical in that it creates harm, I contend that since it is matter of life and death, it should not be allowed in South Africa. Conscientious objection in developed countries like Italy limit women's access to safe reproductive services (Fiala & Arthur, 2017b, 2017a). With limited resources South Africa cannot afford to allow an unethical right such as conscientious objection which will further erode the little available.

There are serious economic and psychological consequences of being forced to carry a pregnancy to term that a person does not want to. Becoming a single mother at fifteen years old changes the course of many a young girl's life. Many have plans to become doctors, engineers, philosophers, university lecturers etc. And, as it is often the case in South Africa, some of these young girls fall pregnant as a result of sexual violence. The children they are forced to bring up under very difficult conditions are more likely than not, to end up in exactly the same situations at their mothers. The economic consequences of carrying unintended and unwanted pregnancies to term can and indeed do transcend generations. It stands to reason then that it is not in the interest of women to carry these pregnancies to term and that those who choose to have a termination of pregnancy ought to be given one. To deny them one is to go against the ethical principle of non-maleficence.

Clearly not all women who have unintended pregnancies and are refused safe terminations will end up dead through an illegal termination. Nor would every woman denied a termination end up in poverty. Though in South Africa more women refused a termination are poor and the refusal will worsen their economic situation. My argument is simply that it is not in the interest of women seeking a termination of pregnancy to be refused one, and that such refusal violates the principle of non-

maleficence. It may be the case that some treatment refusal is justified on sound moral reasoning such as that a woman is acting selfishly when she chooses an abortion, but conscientious objection does not qualify as good ethical reason in itself and as such violates the principle non-maleficence.

### 4.3.2 Interest of Society

The serious pandemic that is unsafe termination of pregnancies is not only an individual issue but a serious public health challenge. An estimated sixty-eight thousand women die annually from unsafe terminations and millions more are injured (Grimes et al., 2006). Many of these women are injured permanently. They then have to depend on society for support. About 20 – 50% of women who have an unsafe termination of pregnancy will end up in hospital with complications such as haemorrhage, trauma to the cervix or sepsis. This overburdens an already under-resourced health care system taking away resources that could be used elsewhere had a medically safe termination of pregnancy had been provided in the first place. It is therefore my conclusion that conscientious objection in constraining the health system takes away resources from society. It takes away what is advantageous for society to have. It is against the interest of society and as such breaks the principle of non-maleficence.

In addition, where women with no means to fulfil their obligation as parents are caused to have children, they have to depend on the state for support. In South Africa, state support is in the form of social grants. In 2018 the child support grant was about four hundred Rand (R400.00) a month. The total budget for social grants is about one hundred and ninety-three billion Rand which includes old age and disability grants. It is often said that to educate a woman is to educate a nation. I make the argument that

giving pregnant teenage girls the opportunity to fulfil their potential through education by offering them safe terminations will reduce the entire social grant budget. More children than people want to have harms the interest of the state and society.

A statistical study in the United States linked legalising termination of pregnancies to reduction in violent crimes such as murder eighteen years later (John Donohue III and Steven Levitt, 2001). The conclusion from the study is that “unwanted” children end up in crime, especially violent crime. There have been several studies since disputing some of the claims made. However, there is consensus that teenage pregnancy, low level of education of the mother and the absence of a father in the home all combine to increase the likelihood that a child may commit crime later in life (Shoesmith, 2017). All these factors predicting crime in later life were found to be present in an unwanted pregnancy study in Kwazulu-Natal (Haffejee et al., 2017). Although a study on crime and termination of pregnancy has not been conducted in South Africa, it is likely that what is seen globally obtains in South Africa as well. At the very least, there is a link between conscientious objection (which has no firm legal basis in South Africa) and the crime of illegal termination of pregnancy in South Africa. Conscientious objection contributes to crime rates by forcing women to have children they do not want or go to illegal backstreet operations. Higher crime rates do in fact disadvantage society. This of course goes against the principle of non-maleficence and as such is unethical.

### 4.3.3 Interest of health care professionals

Health care professionals who do not object to termination of pregnancies have an increased workload. This increased workload can result in low morale, burnout, and staff leaving the profession or emigrating. It is in no one’s interest to have them do more than their fair share of the work. Conscientious objection is not in the interest of

health care professionals who do not object. It therefore goes against the principle of non-maleficence.

In general, conscientious objection gives the profession a bad name given that it breaks medical promises, is vicious, and does not respect ethical principles. Conscientious objection causes serious harm to the reputation of the profession.

### 4.4 Justice

In this section, I will outline what the principle of justice means. And argue that in the case of conscientious objection to reproductive health services, there is an unfair distribution of burdens and unfair distribution of justice. Taken together, these arguments show that conscientious objection is unethical as it violates the principle of justice.

The ethical principle of justice has to do with fairness. According to Childress, a person has been treated justly if they are treated on the basis of what is fair, due or owed (Beauchamp, 2016 p8). The word “fair” here is in the sense of treating people equally without discrimination or favouritism. In in public health care, the principle of justice is often discussed in terms of fair distribution of resources so that available resources (benefits) are shared equitably amongst the population. It is an unfair and unjust system where the heavy burdens of diseases are carried by one group while the benefits of treatments are restricted to a select few due to conscientious objection.

In other words, we assess a case or a situation as unjust if similar cases are treated differently. The principle of justice requires us to treat similar cases consistently in like manner except where there are material differences to justify treating them differently. Health care is mostly concerned with distributive justice but there could be cases of procedural justice. That is where the process followed to get to the decision is

consistent for all cases. Whether some can jump the queue in order to access some medical resources while others have to wait in line. In terms of conscientious objection, procedural justice concerns constructive obstruction where the process is unjustly delayed thereby preventing termination of pregnancy service seekers from obtaining services due to them.

In this section, I will limit my arguments on conscientious objection on the ethical principle of justice to "distributive justice"; that is the fair distribution of available health care resources. In order to adequately comply with the ethical principle of justice, there should be little or no unjustified "discrimination" or "favouritism" in who can access treatment or who carries the burden of disease and downstream consequences (Blake, 2007).

### 4.4.1 Distribution of Health Burdens

The principle distributive justice holds that it is unfair to discriminate against someone on the basis of something they cannot do anything about. Discrimination on the basis of gender, race, or age would be unfair because one cannot for example will themselves into a different race or gender[2]. Throughout this report the massive demand for reproductive health services in South Africa has been highlighted. The scarce health human resources available to the state has also been highlighted as a major issue. Conscientious objectors to termination of pregnancy seek an exemption not only from the law but also from their professional and moral obligations. The obvious inference being discrimination against those who do not object.

[2] Exceptions like Rachel Dolezal a White woman who self-identified as Black for many years before she was outed by her parents or the very public case of Caitlyn Jenner which raises a lot of ethical issues.

Studies conducted in Italy, where upwards of 78% of gynaecologists are conscientious objectors, show an increased workload for non-objectors. More importantly, there is a delay of up to 21 days from request to termination of pregnancy (Bo, Zotti, & Charrier, 2015). As a direct consequence of conscientious objection, the entire workload of termination of pregnancy services is carried by 22% of gynaecologists. It is important to note here that in Italy, only qualified gynaecologists are allowed to perform termination of pregnancies. Although figures are not available in South Africa, in principle conscientious objection is unjust because it always involves an unfair distribution of workload. On those grounds, conscientious objection goes against the principle of justice.

### 4.4.2 Socioeconomic Injustice

The issue of limited access to available resources is highlighted in an IOL article (Silekwa, Siemann, & Shaik, 2018). The article describes how young women seeking termination of pregnancy at Addington's Hospital in Durban have to sleep on the pavement overnight in order to access services. The termination of pregnancy unit at this hospital serves only ten women a day on a first come first served basis. The experience of these women at this hospital is not only linked to limited resources but of course to termination of pregnancy. The article makes the point that although there may be limited resources for renal failure patients, they will not be made to sleep overnight on the pavement and/or limit the number of those served to only ten. Due to the fact that only ten women can be seen a day, many of those seeking these services at Addington Hospital will not get them. And such scenes repeat themselves in poor areas throughout South Africa. Those seeking termination of pregnancy services at Marie Stopes Clinic in Sandton do not face the same difficulties and will more likely than not receive the services they pay for.

Discrimination in terms of access to reproductive health care services based on poverty is unethical according to the principle of justice. Those born into poor families are more likely to end up requiring termination of pregnancy as exemplified by a BBC World News article featuring 17-year-old Kholofo a mother of twins living with her thirty five year old unemployed mother and 53-year-old grandmother (Fihlani, 2018). But they are least likely to receive such services. Some of the discrimination in access to reproductive health care in South Africa may be explained by historical context and limited resources available to the state. However, refusing treatment based on personal religious and moral beliefs exacerbates the issue. On those grounds, I have argued that conscientious objection to termination of pregnancy is unethical based on the principle of justice.

### 4.4.3 Gender injustice

There is also the fact that only women fall pregnant and as such are the only ones who will require such treatment. Given the history of migrant labour in South Africa and perhaps culture, mostly women are going bring up children they did not wish to have in the first place. This is of course not a fair distribution of tasks and conscientious objection does nothing but compound the problem.

### 4.4.4 Global injustice

Developed countries especially those in northern Europe disallow conscientious objection to termination of pregnancy. Developing countries like South Africa who do not disallow conscientious objection have and will continue to fall victim this unjustifiable immoral practice. It may be that even if conscientious objection were morally right (which it is not), it may be ethically justified to disallow conscientious

objection in order to treat women in South Africa in the same way as women in the developed world.

In general, conscientious objection discriminates against women, discriminates against non-objectors, discriminates in the distribution of resources and discriminates against diseases types. Renal failure which may lead to death takes priority over termination of pregnancy which in some cases also leads to death. Conscientious objectors seek unfair exemptions for themselves above others.

## 4.5 Conclusion

Conscientious objection is unethical according to principlism because first it does not respect the agency of women to make their own decisions. Secondly, it is against the interest of women and against the interest of society. Finally, conscientious objection is unfair in the distribution of burdens and benefits of treatment. Principlism provides an easy framework to assess medical decisions. It may be argued that the ethical principles do not actually capture the real content of the normative principles they are derived from. However, there are easy to comprehend and apply. Taken together, these principles clearly demonstrate that conscientious objection to termination of pregnancy in South Africa is ethically wrong.

# 5. Conclusion and Recommendations

In this report, I have used Kantian ethics, virtue ethics and principlism to show that citing personal religious and moral beliefs to refuse professional reproductive services is morally wrong. In many instances, I have shown that the consequences of such treatment refusal are dire. In South Africa as elsewhere, I draw the conclusion that there are moral grounds in limited cases to refuse to provide an abortion. These include cases in which there are no medical or social reasons to provide a termination of pregnancy. Health care professionals might find good Kantian or virtue theory reasons to refuse termination of pregnancy services to a married well-off couple with a health thirty weeks pregnancy. However, there is no moral justification to refuse to provide such services on the basis of conscientious objection (personal "moral" or religious beliefs of the health care professional). As detailed earlier, I also draw the conclusion that it will be morally wrong to coerce health care professionals to perform acts that they choose not to perform, at all times, the onus ought to be on the conscientious objector to show that their actions in each case are based on factual evidence and sound moral reasoning not personal religious beliefs.

## 5.1 Rights

In South Africa, conscientious objectors defend their position not on the basis of Kant, virtue ethics or principlism or even other normative ethics theories such as utilitarianism. Their position has always been defended on the basis of constitutional rights. McQuoid-Mason (2010a) and C. Ngwena (2004) have pointed out that conscientious objectors in South Africa point to their rights as enshrined in section 15 of the South African constitution (South Africa, 1996). This section guarantees the right to freedom of conscience, religion, and thought. Essentially, everyone in South Africa

has freedom of conscience and it will go against the constitution to force anyone to act against their conscience. One view of conscience here could be the one of a morally empty box into which moral values can be put. Thinking along those lines, I can demand that anyone can or cannot do such and such because it offends my conscience and I have a right to my conscience guaranteed by the constitution.

Another view of conscience is a human faculty for moral reasoning such as intellect which is used to perceive objective moral order in the world (Swan & Vallier, 2012). In this sense, the right to conscience is a natural right because conscience is not given to anyone by the constitution but rather acquired naturally. And as such, is a right that should be protected in the same way that a woman's right to her body is protected. The same South African constitution in section 12(2) guarantees a woman's right to bodily integrity including to make decisions concerning reproduction. This right to make reproductive decisions is not in the hands of the health care professional, but it may conflict with her right to conscience. Formal equality requires that since people are the same, they should be treated the same (Stephens, 2017). If a woman has a right over her body so too should a health care professional have the right act or not act according to her "moral faculty" called conscience. It will be unfair for the state to grant one a right over her body and not the other the right over her conscience. Therefore, using a rights approach, one could come to the conclusion that conscientious objection should be allowed in South Africa - this approach overlooks knowledge disparities that make the doctor-patient relationship unequal.

Ngwena (2014) argues that South Africa's lack of a conscientious objection clause in the CTOP act was not an oversight. The original version of the act included such a clause, but it was removed because it was seen to limit a woman's right to termination of pregnancy. Vulnerable women's right to unfettered information to make decisions

on their reproductive health outweighed a privileged health care professional's right to conscience.

This report has highlighted the vulnerability of mostly young and poor women seeking termination of pregnancy services from state hospitals. Vulnerability theory (Stephens, 2017) holds that the state has moral responsibility to protect the most vulnerable people in society. It is on the basis of this that the state justifies policies to address socioeconomic inequalities in South Africa. The vulnerability of women strengthens the argument that South Africa should outright disallow conscientious objection to termination of pregnancy except in cases where it can be empirically verified that the psychological well-being of the health care professional will be seriously harmed. Harming the psychological integrity of health care professionals cannot be justified using any of the normative ethics theories discussed in this report. And it is neither in the interest of the health care professional or society for her psychological integrity to be harmed.

The current right to conscientious objection by health care professionals in South Africa is derived from a statute in England (section 4(2) of the Abortion Act of 1967) (McQuoid-Mason, 2010a). The use of a clause from England is purely as a result of South African law's silence on this critical issue. This report recommends that in addition to disallowing conscientious objection in all but exceptional circumstances, South Africa should clearly limit the use of this current justification either through legislation or regulation by professional bodies such as the Health Professions Council of South Africa (HPCSA).

The relationship between "rights" and morality is not limited only to David Hume's argument that humans ought to have a natural right to their bodies or Kant's argument

that we have a moral right of freedom. Andorno (2016 p.31) highlights the fact that the atrocities of World War II and the Holocaust revived ethical principles in the Nuremberg Code in 1947 and the Universal Declaration of Human Rights in 1948. So too we see South Africa's human rights-based constitution arising in 1996 following Apartheid. The same constitution ought not be used to deny women their rights based on freedom to cite personal religious beliefs.

### 5.2 Registration of the claim to conscientious objection

I recommend that since there is no moral justification for conscientious objection, and the right to conscience should be superseded on the grounds of vulnerability, those who currently insist on objecting to termination of pregnancy services based on personal religious beliefs be registered with a regulatory body. A body such as the Health Professions Council of South Africa (HPCSA) can keep a record of all conscientious objectors to termination of pregnancy. In addition, medical schools ought to screen applicants who voluntarily apply to join the medical profession. This suggestion previously made by Savulescu & Schuklenk (2017) ensures that students learn the requirements of the professions. The screening process could include practical cases that expose students to ethical reasoning. The aim of the screening is not to refuse students places in medical schools but to ensure that not students do not only focus on their clinical and scientific training but the ethical requirements as well. Requirements for the position can also be emphasised in work contracts to ensure that health care professionals perform their moral duties. This is the case in Sweden which does not have the problems of South Africa.

Registering conscientious objection with the HPSCA will allow South Africa to ensure that there are enough non-objectors in all localities. It will help prioritise services where

there is a need. At the moment, South Africa does not know how many objectors there are in the health system. In addition, this process will help eliminate those who object in order to get out of difficult tasks rather than on the basis of conscience. The substantive burden of proof to refuse legal, medically indicated, and socially acceptable treatment will be on the health care professional. All applicants to be registered as conscientious objectors should demonstrate that they have reflected on their duties as enshrined in the Pledge and that they understand the core values of medical practice. They should also show that they understand the rights of the patient to access professional services and the consequences of denying them this access. The HPSCA or a board of ethics professionals will examine each application for sincerity, strength of arguments, and reasonability. Those whose applications are successful will be required to compensate society for such exemption in performing other duties determined not to conflict with their conscience.

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