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Obstetricians/Gynecologists' Conscientious Objection to Providing Induced Abortion Services in Ghana: A Medico-Legal and Policy Situational Analysis

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Abstract

The amendments to Ghana's abortion law since 1985 have made it more liberal to provide elective abortion services under the current abortion law of Ghana. Despite the selective liberalization of assessing induced abortion services in Ghana generally, assessing second trimester-induced abortion services in particular, are only legally permissible in registered hospitals and is to be done only by Obstetricians/Gynecologists. With the limited availability of designated 'abortion hospitals' headed by Obstetricians/Gynecologists' in Ghana, one will therefore wonder why Ghana should endorse a policy or legal backing for conscientious objection to providing abortion services by trained Obstetricians/gynecologists whom are the most qualified health professionals certified to providing second-trimester abortion services in Ghana as deemed appropriate. The main objective of this paper is to critically discuss Conscientious Objection to providing induced abortion services within the policy and legal framework of Ghana and unearth the implications of Obstetricians/Gynecologists' Conscientious Objection to providing induced abortion services on safe abortion care in Ghana From a perspective of medico-legal and policy situational Analysis on the topic, I argued that the legal and policy provisions of conscientious objection to providing induced abortion services in Ghana, particularly specialist Obstetricians/gynecologists' is professionally unethical and social injustice, hence must be scraped to enhance access to abortion care.

Keywords: Abortion; Conscientious Objection; Ghana; Human Rights; Injustice in healthcare

Introduction

Induced abortion in Ghana was selectively criminalized since 1960, unless it was performed by Obstetricians/Gynecologists in a registered hospital, in situations where a pregnancy endangers the life of a pregnant woman, medically diagnosed gross fetal abnormalities, pregnancies resulting from rape, incest, and defilement of female `idiots' [1]. In 1985, the law was modified to mandate trained medical officers and midwives to provide first-trimester abortions in health facilities registered by the Ministry of Health [2]. In 2003, the National Reproductive Health Policy Standards and Protocol to guide abortion care was created and revised in 2013 to include comprehensive abortion care as permitted by law. This also includes provisions for conscientious objection to abortion by healthcare workers for moral reasons [3].

In this paper, a Medico-legal and policy situational analysis of Obstetricians/Gynecologists' Conscientious Objection to providing induced abortion services in Ghana was done. I argue against the legal and policy provisions of health workers, particularly trained Obstetricians/Gynecologists' conscientious objection to providing induced abortion services in Ghana. Conscientious objection to abortion in this paper refers to the practice of medical professionals refraining from providing abortion services and/or participating in abortion treatment for religious, moral, or philosophical reasons, whereas a gynecologist (GYN) is a physician who specializes in treating diseases of the female reproductive system. An obstetrician (OB) specializes in pregnancy and childbirth.

Contextual issues on conscientious objection to abortions

Around the world, continents, and nations, there has been intense debate about the conscientious objection of physicians to providing abortion services. Various writers [4,5]. on conscientious objection to abortion services have argued their stance against a conscientious objection to abortion based on the principle of religious freedom. However, the contextual discussion specifically addressed the fact that healthcare providers cannot opt out of participation in procedures designed to save life or preserve health. Consequently, in situations requiring conscientious objection to providing abortions on religious grounds, a healthcare provider who conscientiously objects to the provision of an abortion service must refer the client to a healthcare provider who does not object to providing abortions. In addition, in situations where healthcare workers refuse to accept procedures to object to abortion seekers' requests, must ensure that non-objective providers have adequate access to assist abortion seekers within national limits. It is therefore important to have systems in place to ensure that non-objecting providers are reasonably assessable to assist abortion seekers within the confines of the national and local laws on abortion.

In many jurisdictions, health workers` conscientious objections to participating directly in abortion and related procedures which they find religiously offensive to them should be accommodated by their professional colleagues, partners of pregnant women requesting the abortion service, and society as a whole. However, whilst under training, it is advisable that trainee Obstetricians/Gynecologists in various teaching hospitals or other health training institutions, cannot object to giving the abortion seekers the required support nor object to being educated about abortion procedures in which they would not participate, but they may object to having to perform abortions even under supervision. As indicated in the Ghana abortion law, the clinical standards, and protocols, hospitals cannot usually claim an institutional conscientious objection, nor discriminate against potential staff applicants who would not object to participation in all or some aspects of abortion procedures.

In a paper titled 'Conscientious objection and health care: A reply to Bernard Dickens' several arguments against proponents of health care professionals' conscientious objections to clinical procedures in general and induced abortion care, in particular, was made [6]. Kaczor explained that in the writings of Bernard Dickens, on conscientious objections, deliberate efforts were made to undermine the legal and ethical protections afforded to medical and hospital workers who oppose abortion for reasons of conscience. Kaczor cites various examples to support his claims: First, Kaczor relies on the justification of anti-discrimination laws as the basis for an argument against conscientious objection. Second, Kaczor argued that conscientious objection undermines the rights and autonomy of patients. Third, Kaczor argued that doctors have a duty of conscience to recommend abortions to their patients. Fourth, Kaczor believes that Kant's principle of respect for humanity as an end is violated by conscientious objection to abortion. Fifth, Kaczor indicated that quotations by Dickens from the remarks of Pope John Paul II as support for the idea that physicians should not conscientiously object to abortion are misleading. Finally, Kaczo further argued that mission hospitals, such as Catholic hospitals and other faith-based health facilities, have a responsibility to provide abortions where there is a need to a save life. Kaczor just like others who are not in favor of conscientious objection to providing induced abortions argues that all of the arguments offered by Dickens and others against conscientious objection are professionally unethical [7,8].

Discussions

In the past, the decision-making for seeking pregnancy termination or refusing to provide an abortion service worldwide has been argued mainly from cultural, legal, and moralist perspectives [9-12]. In recent times, however, the focus on Sexual and reproductive rights and the human rights agenda has made issues relating to abortion decisions increasingly become a human rights issue across the world, [13-15]. thereby making the rationale for seeking or providing safe abortion services, to go beyond the cultural, legal, and moral restrictions to encompass right based decisions that give the freedom of choice which has made induced abortion services continue to exist in many countries across the globe including those countries even with hither-to restrictive laws to make legal provisions for induced abortions on health grounds.

Ironically, there still remain some barriers to accessing safe abortion care worldwide in the form of conscientious objection to providing abortion services within the health system that denies access to care. In modern times, advances in medicine and advocacy for advancing women's rights to reproductive health care have enhanced reproductive health care for many women who hitherto had an unmet need for essential Reproductive health services including medically induced abortions [16-19]. Despite what I like to call the liberalization of slavery in the field of reproductive health, obstacles still exist, including those related to conscientious objection by trained health workers [20-23]. These obstacles can pose risks to women's health and the exercise of their fundamental human rights to reproductive decisions, including decisions related to any form of restriction or limits to reproductive health care and related services.

Amendments to Ghana's abortion law since 1985 have made it more liberal to provide elective abortion services under the current abortion law of Ghana. Despite the selective liberalization of assessing induced abortion services in Ghana, assessing second trimester-induced abortion services, in particular, are only legally permissible in registered hospitals and is to be done only by Obstetricians/Gynecologists [24,25]. With the limited availability of designated 'abortion hospitals' headed by Obstetricians/

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Gynecologists in Ghana [25], one will therefore wonder why Ghana should endorse a policy or legal backing for conscientious objection to providing abortion services by trained Obstetricians/gynecologists' who are the most qualified health professionals certified to providing second-trimester abortion services in Ghana as deemed appropriate.

Is conscientious objection to abortion a human rights issue?

The 1946 Constitution of the World Health Organization (WHO) [26], stipulates "the highest attainable standard of health as a fundamental right of every human being". Recognizing health as a human rights issue ensures access to timely, acceptable, and affordable medical services of adequate quality and provides basic health determinants such as clean drinking water. Brings obligations to individuals and communities. Hygiene, nutrition, housing, health-related information and education, and gender equality [27]. The current human rights-related issues in Health Care service delivery evolved around Concerns of High Cost, Health Equity, Technological challenges, Value-Based Care, client-centered care, and concerns about a shortage of healthcare providers.

A human rights-based approach to health perspective provides a clear set of principles for defining and evaluating health policy and service delivery that target discriminatory practices and undue power dynamics at the heart of unequal health outcomes. In pursuing a rights-based approach, health policies, strategies, and programs are expected to be expressly aimed at advancing the benefits of the WHO's call for human rights to health for all, while not being rights-based seems to be overemphasized. The actions of health care providers in determining what types of health care services they provide, when and where they are provided, are part of a rights-based approach to health care regarding accountability, participation, equality, and non-discrimination in the provision of health care. With this in mind, Obstetricians/Gynecologists are expected not to violate basic principles and standards in providing medical services which they were trained to provide by mere conscientious objection to providing abortion services in Ghana.

Many professional organizations in the healthcare sector are calling for pressure on healthcare providers to take responsibility for respecting human rights in patient care. However, there is also a growing movement to recognize the importance of the participation of non-healthcare actors in defending and protecting human rights in health care. Participation requires all involved medical personnel to own and control the development process at all stages of the clinical programming cycle including recruitment, training, evaluation, analysis, planning, implementation, monitoring, and evaluation; In this respect, involvement goes far beyond advice and technical complement to project design. It must include clear strategies to ensure that citizens, especially the most marginalized, have their voices heard and their expectations of health care met. Participation is key to accountability. Because integrated leadership provides "checks and balances" that do not allow the haphazard exercise of power. I further note that conscientious objections by obstetricians/gynecologists to provide abortion services in Ghana violate principles of equality and non-discrimination in the provision of essential health care, such as access to abortion services.

In my view, the principle of non-discrimination in such a situation seeks 'to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political, or other opinions, national or social origin, property, birth or other statuses such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation.' Any discrimination, for example in accessing abortion care, as well as in means and entitlements for achieving this access, must be prohibited. This is in accordance with the focus of the United Nations Committee on Economic, Social, and Cultural Rights, (2000) [27]. Functioning national health information systems and availability of disaggregated data is essential to be able to identify Obstetricians/Gynecologists who conscientiously object to providing abortion services for the appropriate actions by the appropriate stakeholders in health.

I argued that Obstetricians/Gynecologists' conscientious objection to providing induced abortion services in Ghana is discriminatory. Presumably, in the case of conscientious objection by this cadre of highly skilled medical professionals, the refusal to provide abortion has to do with the convictions of particular medical professionals about the morality of abortion and wouldn't selectively favor any particular group. In my personal considered view, health workers end up specializing in an area of interest regardless of their moral stance. It is therefore very confusing for one to specialize and become an obstetrician/Gynecologist only to refuse to provide abortion services on grounds that it conflicts with one's moral stance. The immediate questions that come to mind in a situation like this are: Is induced abortion a human rights issue or a case of injustice in healthcare? I further asked the question that is it the idea of Obstetricians/Gynecologists' conscientious objection to providing induced abortion services that are discriminatory toward women, or women with certain kinds of moral beliefs towards induced abortion that drives Obstetricians/Gynecologists to declare conscientious objection to providing induced abortion services?

The literature on applying theory to practice in this regard is limited [28]. This becomes even more precarious when it comes to obtaining a rationale/basis for obstetricians'/gynecologists' conscientious objection to providing induced abortion services. Nevertheless, Virginia Henderson's theory in nursing described the nurse's role as substitutive (doing for the person), supplementary (helping the person), and complementary (working with the person), with the goal of helping the person become as independent as possible [29], may provide some window of hope

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in situations where Obstetricians/Gynecologists conscientiously object to providing abortion services but by their training have a duty to ensure that abortion seekers are helped in line with the core values in Virginia Henderson's theory [i.e. substitutive (doing for the person), supplementary (helping the person), and complementary (working with the person)]., to achieve their reproductions intentions.

Regardless of the circumstances, each of us has the right to choose what to do in life and what to refuse for various reasons. These decisions are usually seen in the light of human rights lenses. Physicians have taken the Hippocratic Oath for centuries [30]. The oath exemplifies the basic modern ethical principles of charity, harmlessness, and confidentiality. Its main message focuses on patient well-being, not banning surgery, euthanasia, and abortion as is commonly believed. The Declarations in the Hippocratic Oath taken contains a set of ethical rules intended to guide the medical profession [31,32]. While the original Hippocratic Oath included a trinity of physician, patient, and god, the revised version includes only physician and patient, holding the gods accountable [31].

But what of in the medical professional settings where Obstetricians/Gynecologists are trained to provide Obstetrics and Gynecological services including induced abortions, go ahead to swear an oath to provide that service either explicitly or implicitly but later turns around to be selective in providing the Obstetrics and Gynecological services excluding abortion care, because of conscientious objection to providing induced abortion services. Although there are no documented explicit penalties imposed on physicians in Ghana who break this oath, adherence to the principle is a time-honored tradition for medical practitioners This obviously raises many questions as to why in the first place the medical officer opted to specialize in Obstetrics and Gynecology.

At what point in his/her training did the convections of conscientious objection to providing induced abortion services occurred? Should the professional bodies regulating the practice of medicine in Ghana (Ghana Medical and Dental Council) endorse Obstetricians/Gynecologists' claims of conscientious objection to providing induced abortion services particularly when the ratio of abortion seekers to Obstetricians/Gynecologists is very small? Admittedly, in Ghana, most abortion providers are not specialists. However, by the Ghanaian abortion law [1,2], and policy [3], all medical practitioners are expected to provide abortion services in emergency situations. In my view, these legal and policy provisions should be operationalized beginning with Values Clarification and Attitude Transformation (VCAT) [33], of potential abortion providers focusing on educational interventions that involve their personal values, sociocultural, and cross-cultural reflective processes to enable them to explore their interests, choices, behaviors, and responses in a variety of interpersonal and social situations that may enable them to identify the underlying or influential value priorities towards Abortion care In this regard, VCAT must be done to ascertain the acceptability to provide Obstetrics and Gynecological services including induced abortions by all medical officers opting to specialize in Obstetrics and Gynecology and perhaps should be made a criterion for gaining admission into the Obstetrics and Gynecology specialty to acquire specialist training to become Obstetricians/Gynecologists. With this, how convincing then would a case of conscientious objection to abortion be justified in Obstetrics and Gynecology, and on what basis could that be justified?

Many medical professionals, including obstetricians and gynecologists, have presented cases of conscientious objections to abortions in a variety of persuasive ways while protecting the rights of abortionists [34,35]. I think this counterargument is very persuasive and could even be stronger if we can successfully demonstrate that even what we think of as "choice" depends on factors beyond our control. Therefore, not all choices are completely voluntary. In as much as this may sound like an objection to my earlier arguments on Obstetricians/Gynecologists' conscientious objections to abortions, I hold the view that, if an obstetrician-gynecologist is trained in an environment where abortion is stigmatized for moral reasons, it may be difficult to perform an induced abortion regardless of the professional skills acquired in abortion care, hence he/she is more likely to conscientiously object abortion. But my sustained arguments all this while is, why then should one decide to specialize in a field such as obstetrics/-gynecology knowing very well that the required services to be provided in that field contradicts one's moral stance? The obvious question that one may ask is should a conscientious objection to abortion be seen as a case of injustice in healthcare?

Is conscientious objection to abortion a case of injustice in healthcare?

As discussed in previous publications [36,37], abortion seekers are typically vulnerable to epistemological fraud. In many cases, abortion seekers are also vulnerable to injustice related to testimony through presumed attribution of traits such as cognitive unreliability and emotional instability that reduce the credibility of testimony. A person who wishes to have an abortion is also vulnerable to hermeneutic injustice. This is because many aspects of making the decision to have an abortion and the experiences gained in the process of doing so are often difficult to understand and communicate due to gaps in collective hermeneutic resources. Epistemological injustice can be attributed in part to the epistemological privilege enjoyed by healthcare workers and institutions of modern healthcare. evaluate and effectively dismiss them as an indirect form of conscientious objection to abortion.

Induced abortion is associated with reproductive injustices across the globe. While the impact of overturning 'Roe' was acutely felt in the United States of America, its repercussions affected the reproductive rights of women in the entire world [38]. In 1994, delegates from 179 countries met in Cairo for the United Nations International Conference on Population and Development (ICPD).

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One of the major resolutions of the ICPD conference held in Cairo led to the harmonization of population policies all over the 179 countries in the world, including the recognition of women's right to access abortion services as permitted by the respective country's laws. The objectives of the Cairo Action Plan were however developed in such a manner that it permitted the adjustment of its provisions to the national laws of individual countries to respect their cultural, religious, legal, and ethical principles [39,40]. Ironically, translating the ICPD Action Plan into pragmatic results has not been as fast as expected within the 179 countries present at the Cairo conference, particularly in the area of ensuring access to safe induced abortion [39], since empirical evidence has shown that the percentages of pregnancy terminations vary significantly in different countries worldwide [41,42].

In an attempt to respond to the question of whether a conscientious objection to abortion is synonymous with a case of injustice in healthcare, the literature shows that induced abortion is totally restricted and prohibited in over 20 countries worldwide [43]. Invariably, access to safe abortion care is ensured by accessibility to trained providers [44,45]. In Countries such as Ghana where the abortion law was relaxed in order to reduce the number of maternal deaths due to unsafe abortions, various socio-cultural and moral norms frustrate national public health efforts of making safe abortion care services accessible to abortion seekers, the worst of all are in the many countries where abortion is still prohibited [44,45]. A seemingly strong movement of conscientious objection to abortion by trained health workers deprive access to safe abortion care as those who are trained and expected to provide safe abortion services to reduce maternal deaths due to abortion rather than their behaviors of objection become barriers to safe abortion as potential clients are turned away in hospitals to 'quarks' [46].

There are many arguments in the literature supporting conscientious objection to providing induced abortion services [47]. Nevertheless, I believe that life is full of choices and every choice in life goes with its associated consequences. Likewise, seeking induced abortion constitutes a choice that is linked to pregnancy crisis management, because health professionals and society neglected a core professional mandate towards preventing unwanted pregnancies or assisting clients to have safe abortions when required without discrimination or being judgmental as in the case of conscientious objection to abortion by some Obstetricians/Gynecologists

I however argue from the perspective of swearing a professional oath (Hippocratic Oath) to uphold the code of practice medicine in a specialized field of Obstetricians/Gynecologists [30,31], against which conscientious objection to abortion on the other hand, violates the obstetrician/ gynecologist's professional code of practice. Despite being aware of it, at what point in the career development of obstetricians and gynecologists did conscientious objections to abortions (anti-abortion behavior) begin? I guess there's a dilemma here as to what the professional code should be and what a professional should decide to do regardless of the professional code of practice. In my personal considered view, if a conscientious objection to abortion is morally permissible, then it also seems morally permissible to have professional codes that make room for conscientious objection. For these reasons, Obstetricians/Gynecologists' Conscientious Objection to providing induced abortion services in Ghana will rather be considered a human rights issue and not a case of injustice in healthcare.

I contend that the acceptance of health care as a universal human right issue requires a variety of national, and local systems for providing health care by trained and certified health workers for the services they are mandated to provide. An international network of rapid communications makes people everywhere aware of the variety of systems and the fact that some systems other than their own show better results, as measured by, for example, preventing the incidence of unsafe abortions in Ghana. Conscientious objection to abortion by some Obstetricians/ Gynecologists should therefore be questioned.

In fulfilling this professional obligation to meet the needs of abortion seekers, obstetricians and gynecologists, and all other categories of health care workers who play various roles in abortion care, must constantly evaluate their roles and be ready to modify them for the common good of humanity as well as meeting the objectives of those trained and mentored in preparation for their work. While the need for abortion is increasing globally and locally as in Ghana, the roles of Obstetricians/Gynecologists as well as all other categories of health personnel are very essential to reduce abortion-related deaths and illness. The most successful preparation of Obstetricians/Gynecologists as well as all other categories of health personnel involved in abortion care in my opinion will, include whatever gives them the broadest possible understanding of humanity and the world in which they live. It will also provide an opportunity to see specialist Obstetric/ Gynecological care given during pregnancy.

To eliminate conscientious objection to abortion by some Obstetricians/Gynecologists it is imperative that health regulatory bodies should implement regulations for healthcare providers on how to invoke conscientious objection without jeopardizing women's access to safe, legal abortion services, especially with regard to timely referral for care and in emergency cases when a referral is not possible. In addition, the ministries of health should take all necessary measures to ensure that all women and adolescents have the means to prevent unintended pregnancies and obtain safe abortions as the need may arise. Upholding conscientious objection to induced abortion by some Obstetricians/Gynecologists in my view constitutes an act of injustice to women`s access to essential reproductive healthcare. This is backed by the Liberal Egalitarian Theory [48,49], which avoids injustice and fairness objections to health care like in the case of objection to providing induced abortion services It can

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however be argued that the fetus is also a patient, hence attitudes toward abortion and referral among physician conscientious objectors could be justified [50].

Looking at the issue of conscientious objection to abortion from a more ethical perspective of equal rights, the key idea is that abortion is a human rights issue and that conscientious objection threatens women's ability to access this right [51]. This argument is both an in-principle argument against conscientious objection as well as an argument that holds on conditions that the provision of abortion services is threatened by the practice of conscientious objection by Obstetricians/Gynecologists in Ghana [52]. I am however inclined to indicate that this argument works best along the latter lines. This is because it turns on the importance of being able to secure the right to an abortion. There are many role players in abortion care in Ghana [53], who are continuously being stigmatized by their associations with abortion care [54]. As long as there are enough providers who can provide the relevant abortion services regardless of the associated stigma, the conscientious objection wouldn't significantly threaten women's rights to abortion services.

Conclusions and Recommendations

This paper argued against the legal and policy permissibility of conscientious objection among Obstetricians/Gynecologists to providing induced abortion services, focusing especially on the case of Ghana. Based on the issues raised in this paper, my position on conscientious objection by Obstetricians/Gynecologists to providing induced abortion services on moral grounds is that its unethical and socially unjustified because it constitutes withholding of essential health services, which connotes injustice in health care. I argue that the rights of Obstetricians/Gynecologists to conscientious objection to providing induced abortion services should be scrapped by law since abortion is a component of their professional responsibilities and refusing to provide abortion services for any reason may constitute a form of professional misconduct. There are many moral arguments for this stance, however, I contend that the moral basis for a medical practitioner, not to provide abortions does not mean refusing or accepting whatever society prescribes without careful deliberations and consideration of the consequences thereafter because an entire society can be morally corrupt when it comes to abortion decisions.

Haven critically reflected on the issues raised in this paper, I recommend that the Ghana Health Service and the health professional bodies in Ghana should consider advocating for a policy directive that will mandate each hospital/institution providing Sexual and Reproductive Health related services to ensure that healthcare providers in the respective hospital/institution must have a quota of willing abortion providers on staff at each particular shift or by appointment to provide abortion services not only on emergency situations but also on-demand as permitted by the country laws. This would guarantee access to abortions while making room for conscientious objection as deemed professionally and ethically appropriate/justified.

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