"The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia

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***CONTEXT**: In 2006, the Colombian Constitutional Court partially decriminalized abortion. However, barriers to access, including improper use of conscientious objection, remain.*

***METHODS**: To explore conscientious objection from the objectors' perspectives, in-depth interviews were conducted in 2014 with 13 key informants and with 15 Colombian physicians who self-identified as conscientious objectors. Recruitment included snowball and purposive sampling techniques. Analysis was conducted in tandem with data collection and focused on objectors' attitudes, beliefs and behaviors related to abortion and referral.*

***RESULTS**: Objectors had varied perspectives. Three types of objectors were evident: extreme, moderate and partial. Extreme objectors refused to perform abortions or make referrals, and often lectured their patients; they also provided misleading or false medical and legal information, preventing women from accessing abortions to which they were legally entitled. Moderate objectors would not perform abortions, but respected their patients and viewed referral as a way to save "one out of two" lives. Partial objectors performed some abortions but refused to do others on the basis of gestational age or case-by-case circumstances. Across the typology, objectors linked conscientious objection with medical ethics, and many described a duty to protect the fetus, which they conceptualized as a patient.*

***CONCLUSION**: Conscientious objectors exhibit diverse opinions and behaviors. Potential areas for future investigation include identifying factors that lead objectors to refer and estimating the prevalence of each type of objector. Results suggest potential interventions that could reduce the role of conscientious objection as a barrier to care.*

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Each year, an estimated 47,000 women worldwide—more than 128 women per day—die from complications of unsafe abortions.[1] A further eight million women experience complications requiring medical attention, though only five million receive the necessary care.[2] When women have access to safe and legal abortion services, virtually all maternal deaths from abortion are eliminated, yet the overall incidence of abortion in areas where abortion is legal is no higher than that in places where access is restricted.[3–5]

In Latin America, abortion is responsible for 12% of maternal deaths.[6] If safe abortion services were legal and accessible everywhere, the proportion of maternal deaths attributable to abortion most likely would be negligible. In the United States, where abortion is available to women who navigate a patchwork quilt of legal and logistical barriers, induced abortion is safer than childbirth.[7] Fewer than 0.5% of abortions in the United States result in major complications, and fewer than one in a million of those performed before eight weeks' gestation end in maternal death.[8]

In contrast, morbidity and mortality from abortion have been very high in Colombia, where the procedure was illegal under all circumstances until 2006 and remains difficult to access. Estimates suggest that in 2008, the vast majority of abortions were performed illegally and unsafely, and 24–53% of illegal abortions resulted in complications; the risk was highest among poor women living in rural areas.[9] Moreover, an estimated one-fifth of women with abortion complications did not receive treatment,[9] and approximately 70 women died from their complications.[10] Nonetheless, the partial decriminalization of abortion in 2006, accompanied by implementation policies geared toward improving patient outreach and expanding access, was an important step toward reducing maternal morbidity and mortality.[2,11]

Decriminalization

The key event in the decriminalization of abortion was a ruling issued by the Colombian Constitutional Court that legalized abortion in three circumstances: when the life or health of the mother is at risk; when a severe fetal malformation is "incompatible with life"; and when the pregnancy is the result of rape, incest or forced insemination. The Court's groundbreaking ruling, known as C-355/06, established a fundamental right to abortion in these three situations.[12,13] The court clarified that risk to the "health of the mother" includes her mental well-being, because a woman has the right to enjoy the "highest attainable standard of physical and mental health."[14] The ruling transformed abortion from a crime punishable by years of

imprisonment to, under the broad circumstances outlined in the law, a constitutionally guaranteed right.[13,15,16] This has implications for conscientious objection, which "cannot be invoked with the effect of violating women's fundamental rights to lawful health care."[17]

Decriminalization of abortion can have a significant impact, but it does not immediately guarantee universal access to safe abortion services. In many countries, even after abortion has been decriminalized, procedural, economic, informational and cultural barriers have continued to impede access to legal abortion services.[2,11] For example, more than three decades after India decriminalized abortion, the majority of procedures still took place in informal, illegal and unsafe conditions.[3] Likewise, more than two decades after abortion became legal in Zambia on broad health and social grounds, 12% of schoolgirls and 69% of women in Western Province, one of the poorest provinces in the country, reported knowing someone who had died from an abortion induced outside the health care system.[18] Providers' conscientious objection and their failure to refer are among the most commonly identified barriers to implementation in countries where abortion has been decriminalized.[19]

Conscientious Objection

Conscientious objection is invoked when health care professionals directly involved in abortion provision are exempted or exempt themselves from providing or participating in abortion care on religious, moral or philosophical grounds. It is the subject of litigation, legislation and public health concern in countries around the world.[2,20] Conscientious objection has been identified as an important barrier to abortion access in many countries,[21] including Australia, Canada, India, Ireland, Mexico, Poland, South Africa, the United States and Zambia.[18,22–31] Investigators from the United Nations, concerned about the potential for "disingenuous claims of moral conscience," have called for more research on the extent to which conscientious objection contributes to maternal morbidity and mortality in these countries.[2]

The Colombian Constitutional Court defined conscientious objection as a manifestation of the right to freedom of conscience, but specified that the right is not absolute.[20,32] In addition to outlining the conditions under which abortion is permitted and guaranteed, decision C-355/06 established a legal framework for addressing conscientious objection by physicians who feel that their religious, moral or philosophical beliefs preclude their performing abortions. The decision clarified that the right to conscientious objection is afforded to individual clinicians, and not to institutions or judicial authorities. It further stated that mechanisms must be in place to ensure immediate referral, and that conscientious objection "may not involve disregard for the rights of women."[13]

In the years since the initial decision, case law has consistently upheld the fundamental right to abortion and protected that right against the improper use of conscientious objection.*[20,33] In these cases, the Court enumerated specific limitations intended to ensure that conscientious objection does not become a barrier to the constitutionally protected right to timely and safe health services. Some of the Court's relevant rulings are summarized below:

- Individual health care providers directly involved in abortion provision may manifest their right to freedom of conscience by refusing to perform abortions. Their reasons for doing so must be expressed in writing.[17,20,32]
- Objection need not be based in religious conviction. Objectors may cite secular moral or philosophical beliefs.[34,35]
- Conscientious objection is an individual act; thus, collective conscientious objection is prohibited, and institutions, such as hospitals, do not have the right to conscientious objection.[14,17,20]
- Objecting physicians have a duty to refer, and institutions have a duty to ensure the availability of nonobjecting physicians to whom patients can be referred.[14,17,20]

Despite consistent case law, the regulation of provider conscientious objection has proved challenging and contentious.[20] Improperly exercised conscientious objection, along with cumbersome bureaucratic barriers, leads many women to seek abortion outside of the formal sector, often in unsafe settings.[36] Fundamental disagreements about abortion fuel the Colombian debate, and important actors such as hospital administrators and physicians differ in their interpretations of the ethical, legal and medical requirements defined by judicial rulings.[12] No estimates are available for the number of Colombian physicians claiming conscientious objection, but knowledgeable informants from this study believe that the proportion is substantial enough to be a meaningful barrier to access.

Moreover, little is known about the way conscientious objectors in Colombia understand and practice their objection. Do they accurately counsel and appropriately refer their patients? How do they reconcile perceived professional and religious obligations? To help fill these gaps in knowledge, we conducted this study as part of a larger, interdisciplinary, exploratory investigation regarding the barriers to abortion access that remain in the wake of Colombian decriminalization. Our aims were to understand conscientious objection from the perspective of the objectors themselves, and to identify potential avenues for intervention that could reduce the burden of conscientious objection as a barrier to safe, legal abortion.

METHODS

Study Design and Sample

Data were collected in June and July of 2014. A research team from Emory University worked in collaboration with an advisor at the Universidad de los Andes in

*Cases with language relevant to conscientious objection include T-209 (2008), T-946 (2008), T-388 (2009) and T-627 (2012).

Bogotá and with partners at two Colombian reproductive health clinics.

Study design, data collection and analysis followed a modified grounded theory–based methodology, incorporating an iterative process wherein we began analyzing data while data collection was still taking place.[37] This allowed us to respond to and further examine emerging results. For this study, the iterative process included modifying interview guides and refocusing participant recruitment to explore themes and categories as they emerged.

We interviewed two groups: actors in the abortion debate in Colombia (key informants) and self-identified conscientious objectors. Both groups were recruited through a snowball sampling referral process. Initial participants were identified through contacts at Universidad de los Andes and several local nonprofit organizations, along with cold calls to local hospital research departments and relevant organizations. At the conclusion of each interview, the participant was asked to list friends or colleagues whose perspectives might be beneficial to this study. Interviewees were asked to think about individuals whose views might be different from their own; they then contacted these individuals to explain the study and invite them to participate. All potential participants recruited by friends or colleagues agreed to be interviewed.

Key informants included nonprofit leaders, attorneys, women's rights advocates, bioethicists, a professor of medicine and a city government official. In total, 13 key informants, from different sides of the abortion debate, were recruited for the study.

Inclusion criteria limited the conscientious objector sample to health care providers who were qualified for direct involvement in abortion services but were not willing or able to perform abortions in some or all situations because of their moral, ethical or religious beliefs. Many participants reported having conveyed their objections to others verbally (without a written declaration), collectively (by signing an agreement with colleagues) or on a case-by-case basis—behaviors precluded by the limits to conscientious objection outlined by the Constitutional Court.[14,20,32] Our research shows that these limits are enforced loosely, if at all, and that many objectors whose behavior and opinions were important to this study were not acting within the legal framework. Thus, our inclusion criteria encompassed conscientious objection that did not meet the legal definition.

Fifteen self-identified conscientious objectors—14 doctors and one medical student in her final year of residency—participated in in-depth interviews.[38] Ten were female, but this should not be taken as an indication that objectors are more likely to be female (our sample was not representative). Participants ranged in age from 28 to 69, and had 1–33 years of experience providing health services to women. Eight worked in public hospitals, four in private clinics and three in hospitals affiliated with the Catholic Church. Three nurses were also interviewed, but they were not included in this analysis; despite identifying as conscientious objectors, they participated in abortion procedures, and thus their experiences were different from those of physician conscientious objectors.

Data Collection

A female researcher from Emory University conducted confidential in-depth interviews with each conscientious objector. The interviews took place in a variety of private settings. Most were conducted in a hospital, clinic or university office, but one was conducted at the participant's home and another at the researcher's apartment. All interviews were conducted in Spanish using a semistructured interview guide that evolved slightly during the research process. The interviews were audio-recorded and lasted 30–120 minutes. Interview questions focused on the ethical, moral, religious and legal influences surrounding provision of and referral for abortion services.

Four bilingual American graduate students interviewed the 13 key informants. The interviews took place in a private space at the informant's workplace. Participants were asked a range of questions about the historical, political and cultural context surrounding abortion in Colombia. These interviews were less structured than those conducted with objectors; they focused on the particular knowledge and experience of each interviewee. Key informant interviews lasted 30–60 minutes and were recorded.

Analysis

All interviews were transcribed by a professional Colombian transcriptionist and checked for accuracy by a bilingual researcher in the United States. Data were entered into MAXQDA 11.2.1 and coded for inductive and deductive themes, which were then compared across emergent categories.[37] Analysis was conducted primarily in Spanish; quotes that appear in this article were translated as needed. As is common in qualitative research, analysis began in tandem with data collection.[38] The types of conscientious objection described in the Results section were identified during the first weeks of data collection, and future recruitment focused on capturing this diversity of perspective and experience. Like most qualitative data, our findings are a "joint product of the participants, the researcher, and their relationship."[39(p.531)] With this in mind, we approached data collection and analysis with a reflexive lens—a mindset geared toward "thoughtful, conscious self-reflection."[39(p.532)] This allowed us to carefully consider and reflect on the way our relationships with interviewees influenced the data produced.

We completed three phases of computer-assisted qualitative data analysis: code development, code application, and code-assisted subgroup differentiation and definition. Transcripts were read closely and inductive codes were developed from a subset of the data; these codes were then applied to the entire data set using a standard code dictionary. New inductive codes were added as needed throughout the iterative analysis process. Emergent data categories were explored and compared code by code. The most salient distinctions between types were used to develop the descriptions below.

Ethical Considerations

Ethical approval for this study was obtained from the Emory University Institutional Review Board, and from the ethics committees of Universidad de los Andes, Profamilia and Oriéntame in Bogotá. All participants provided informed consent prior to being interviewed. Key informants provided written consent; because of the sensitive nature of the interviews, conscientious objectors provided oral, rather than written, consent, thus ensuring that their names were not recorded, and providing peace of mind that helped them feel comfortable giving honest answers.

RESULTS

Insights from Key Informants

In the context of Decision C-355/06, "health" can be understood using the World Health Organization definition: a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." Thus, as one key informant—the head of a leading women's health nongovernmental organization based in Bogotá—explained, anyone faced with a pregnancy that is unsustainable (whether for social, economic or physical health reasons) fits the Colombian court's seemingly restrictive criteria and should be able to obtain a legal abortion. However, abortion opponents and some conscientious objectors adopt a more restrictive interpretation of the law; despite extensive case law prohibiting such actions, physicians, especially conscientious objectors, take on the role of gatekeeper in many hospitals. A key informant involved in regulatory oversight pointed out that the "murky" legal situation is complicated by the suspension of Decree 4444, a regulatory ruling that spelled out specific policies for the implementation of decriminalized abortion.

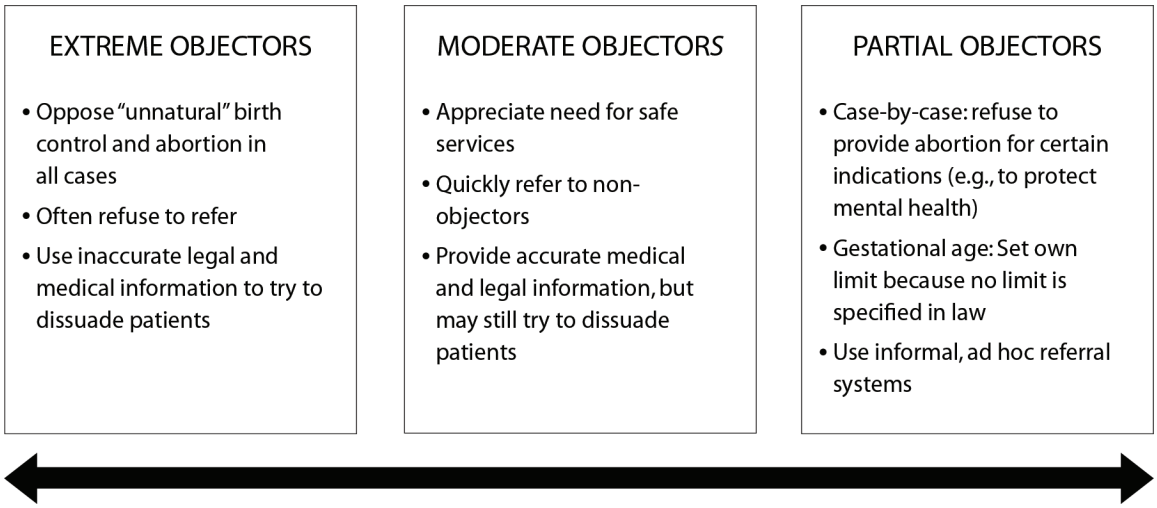
Implementation of regulations around conscientious objection has been inconsistent, according to key informants. Despite case law outlining how and when conscientious objection should be practiced, hospitals continue to set their own policies and practices, which may or may not include maintaining a registry of objectors and clear protocols for referral. Some religious hospitals, key informants reported, continue to claim "institutional objection," despite clear case law disallowing such actions. A physician who worked in one of the implicated institutions explained that she and her colleagues were asked to "voluntarily" sign declarations of objection when they began their jobs at the hospital. She believed abortion activists misunderstand the way the situation is presented: The institution itself is not objecting; it just does not have any physicians who are willing to perform the procedure.

Toward a Typology of Objection

During the interviews, three overarching profiles, or "types," of conscientious objection emerged: extreme, moderate and partial objection. Partial objection can be further split into two subcategories: gestational-age-based partial objection and case-by-case partial objection. The three types can be conceptualized along a spectrum (Figure 1). This spectrum is a simplistic, two-dimensional representation of a complex phenomenon, and the seemingly contradictory or inconsistent views of some interviewees might be better portrayed as a series of dynamic positions along the spectrum than as a static point. Nevertheless, the three types and their organization along the spectrum are useful tools that help us describe the diversity of perspectives.

The idea of the types began to emerge during preliminary coding of the key informant interviews and the first four or five objector interviews. Because we were using an iterative data collection and analysis process, wherein data collection and preliminary analysis took place at the same time, we decided to explore the idea of typology by purposively sampling for each type of objector during the last two weeks of recruitment and interviewing. The final sample comprised six moderate objectors, three extreme objectors and five partial objectors. The partial objectors can be further classified as follows: three objected to abortion after 22–24 weeks because of concerns about viability; one objected to abortion after 14 weeks because of concerns about maternal health; and one investigated the reasons

FIGURE 1. A spectrum of conscientious objection



her patients were seeking abortion and made a decision on a case-by-case basis, described in more detail below.

As data collection and analysis unfolded, the importance of medical ethics, instilled in part during medical training, also emerged. To explore how the views of providers whose medical education occurred after decriminalization might differ from those of providers who were educated while abortion was still illegal, we included in the sample one medical resident, who was categorized as a moderate objector. Given the short time frame of data collection, we were not able to interview any other residents; because the interview did not stand out from those with other moderate objectors, the resident's views are not discussed separately.

Extreme Objection

• *Extreme objectors believed it is their medical, ethical and religious duty to refuse to perform abortions and to prevent them from occurring.* Extreme objectors, informed by Roman Catholic doctrine, believed that life begins at fertilization and that the physician's duty to protect that life, at all costs, begins at the same moment. The extreme objectors were among the most loquacious interviewees, speaking at length about their beliefs from both a biomedical and a religious perspective. Many discussed the comfort they found in their personal relationship with God. Others defined feelings of "medical duty" as their most important reason for opposing abortion.

• *Extreme objectors tried hard to change their patients' minds.* Extreme objectors frequently used the word "compassion" to describe their interactions with patients. When asked to elaborate, they described lengthy conversations aimed at understanding patients' motives for seeking abortion, so that they might convince the women to change their minds. One objector described spending hours with a single patient to "walk in her shoes" and help her see how she could take a different path, such as adoption. Some objectors used harsh, even abusive, language toward their patients if initial attempts to change their minds were unsuccessful. Some shared examples of what they tell patients:

"Think about it. This could have repercussions for you; obviously it has repercussions for the baby." —*Extreme objector, female, age 56*

"This is your child; admit it.... Why do you want me to kill a person? Why do you want me to be an executioner?" —*Extreme objector, male, age 62*

• *Consistency or coherence of belief is very important to extreme objectors.* Proud of their moral consistency, two extreme objectors were determined to explain that they also opposed scientific research involving embryos. Using similar logic, extreme objectors said that they refused to prescribe some forms of birth control—including IUDs, oral contraceptives, emergency contraceptives and surgical sterilization—because they consider them "micro-abortive" and harmful to women's health:

"It seems incoherent to be against abortion but support family planning methods that may be abortive." —*Extreme objector, male, age 42*

• *Extreme objectors provided misleading legal and medical information.* One extreme objector regularly told his patients that their situation did not meet the legal criteria for abortion, regardless of their reasons for seeking one. All extreme objectors described making unfounded or exaggerated claims about the physical and emotional dangers associated with abortion, birth control or both:

"Well, to start, I'd explain that [the women's situation] is not included in the circumstances that the court established as legally permitted, that it's not legal from that point of view." —*Extreme objector, male, age 42*

"Look, this [contraceptive method] is so dangerous that it could kill you." —*Extreme objector, male, age 62*

• *Extreme objectors refuse to refer their patients.* When asked why she does not refer patients, one extreme objector claimed that referrals are unnecessary, because sufficient information is available for women to find services themselves. Another said that he refused to refer patients because he did not want to be an "accomplice" to the "murder of a person."

Moderate Objection

• *Moderate objectors tended to be religious, but were tolerant of other perspectives.* Moderate objectors talked about religion in a more personal, less absolute manner than did extreme objectors. While they were deeply devoted to their faith, this faith did not prompt them to try to create barriers, or aggressively talk women out of having abortions. For example, one objector said:

"I am not the one who is going to execute this abortion, because I think that God has given us life and it's He who retires us, who takes it away, and that's it.... But neither am I going to be the stick in the wheel that's going to stop the process and this decision that another person has already made." —*Moderate objector, female, age 38*

• *Moderate objectors tended to be strong advocates for birth control and emergency contraceptives.* Unlike extreme objectors, moderate objectors believed that modern contraceptive methods are medically safe and scientifically distinguishable from abortion. On an ethical level, they viewed family planning as a method of preventing future abortions:

"Yes, I agree with [use of] family planning methods, 100%, without a single problem. I am not an objector to these methods. In fact, we must promote them, precisely because preventing a pregnancy is preventing a future abortion." —*Moderate objector, male, age 42*

• *Moderate objectors provided referrals.* Moderate objectors believed they had the irrefutable right to refuse to perform an abortion, but they generally agreed and complied with the legal requirement to refer. Some even found comfort in knowing that their patients would receive safe care and would not have to resort to an illegal, unsafe option, such as self-induction or going to a clandestine clinic. As one explained:

"I can't keep that in my conscience, that that patient could get infected, or [get] a perforated [uterus], or many

other things that could happen.... She could even try to take her own life." —*Moderate objector, female, age 38*

• ***Moderate objectors were informed by medical ethics and their commitment, as physicians, to "protect life."*** Moderate objectors believed that their refusal to perform abortions was in line with the commitments they had made when choosing to pursue a career in medicine. One interviewee specifically cited the Hippocratic oath in describing her reasons for objecting to abortion; others discussed their reasons for choosing to study medicine in the first place, explaining that their motives were, and remain, inconsistent with performing abortions:

"Obstetrics is a branch of medicine in which we accompany the mother and we accompany the fetus, and we see all of these biological processes working within and feel a profound respect and admiration for them.... So, the fetus is my patient, too, and to perceive [fetuses] as my patients, well, I'm not going to kill my patients. It's more about this aspect than it is a question of religion." —*Moderate objector, female, age 28*

Partial Objection: Gestational Age

• ***Gestational age–based objectors do not consider themselves opponents of abortion, and are not motivated by religious beliefs***. Most gestational age–based objectors said that they believed women have a right to access safe, legal abortion services, and that they were happy to perform the procedure. Though most identified as Catholic, they did not discuss religion when expressing their reasons for opposing abortion after a certain gestational age.

• ***Many physicians object to performing abortions on potentially viable fetuses***. Colombian law does not limit access to abortion on the basis of gestational age. However, interviewees working at tertiary-level hospitals, where particularly complicated and late-gestation cases are referred, reported that many providers were concerned about performing abortions after 22–24 weeks, a gestational point associated with potential viability. These abortions are performed through induced labor, the interviewees explained. A 32-year-old female partial objector described one such abortion, after which she began refusing to participate in later-term abortions:

Participant (P): So, to perform an abortion where the fetus is born [and] cries, and to leave it to die without giving it any attention, that seems unethical to me.

Interviewer (I): Have you seen an abortion like that?

P: Yes, I've seen it.

I: Can you describe it?

P: They expelled the fetus, and the baby cried and cried, until it suffocated, and there was no pediatric care.... So, that's also a moral concern.

I: How did you feel at that moment?

P: Impotent, for not being able to help, because it's the decision of the mother to leave it to die, and I couldn't do anything to help this baby, because it was the decision of the mother. In contrast, when they are smaller, it's easier... there doesn't exist the possibility of life.

Concerned about abortion of potentially viable fetuses, doctors at one tertiary-level hospital signed a declaration of collective objection. Since then, if a woman comes to this hospital seeking an abortion after 22 weeks, she will most likely be refused the service. One signatory to the collective objection statement said:

"It's against the principles of medicine and medical advances.... It's already a whole different thing, and I think that this isn't about being a partial objector, because now we're talking about an induction, a preterm birth.... We're no longer talking about pregnancy termination." —*Gestational age–based objector, male, aged 46*

• ***Some physicians refuse to perform abortions after an earlier point, citing concerns other than viability***. One interviewee refused to perform abortions after 14 weeks' gestation because of the increased potential for maternal complications. Another described colleagues who perform abortions as long as they can be done with medication (up to 9 weeks), but are not willing to use aspiration or other surgical techniques to perform abortions at later gestational ages.[†] A clinic administrator reported her experience:

"I have two doctors who have said to me: 'Look, I'll do the medication [abortions],' but when I start preparing them a training on aspiration, they say: 'I'm not participating in that.'... I think it's more about the number of weeks [and not the method itself]." —*Moderate conscientious objector, female, age 38*

Partial Objection: Case-by-Case

The perspective of one partial objector, a 32-year-old female, stood out strongly enough to warrant its own category. Although our description here is based on a single interview, comments by key informants and other objectors suggest that this kind of partial objection is not rare; more research is needed, however, to determine its frequency and general characterization.

The case-by-case partial objector we interviewed was willing to perform abortions in cases of fetal malformation, especially those "incompatible with life." In such instances, she viewed the procedure as being in the best interest of the fetus, who was "not going to have a dignified life" given the suffering and inevitable death awaiting it at birth. On the other hand, in cases of rape, she did not perform abortions, because both the mother and the baby "are human beings and both have a right to a dignified life." She was also very suspicious of women's claims about rape; she believed that many women say they have been raped to cover up "less just" reasons for having an abortion, such as feelings of shame for having made bad choices. While she would provide abortions to save a woman's life, she viewed mental health as a subjective, unilaterally determined and

[†]We were unable to interview the nine-week objectors themselves, but the perspectives of such objectors may be an important area for future research.

absurd excuse for terminating a pregnancy. She believed that abortion itself is a threat to mental health.

To put her objection into practice, the case-by-case partial objector relied on a series of informal agreements with her colleagues and superiors. After meeting with a patient, she would decide whether she was willing to perform the abortion. If not, she said, "I refer [the patient] to the other doctor.... I mean, we don't have a card declaring the option, but as there are two gynecologists, generally when there is an abortion with which one of us disagrees, we ask our colleague to perform it."

DISCUSSION

The aim of this study was to understand conscientious objection from the perspective of the objectors themselves, and to identify potential avenues for intervention that could ease the burden of conscientious objection as a barrier to safe, legal abortion. By describing the types of objection, we intend to expand, rather than resolve, a dialogue about the diversity of attitudes and professional behaviors of Colombian physicians who identify as conscientious objectors. If conscientious objectors are treated as monolithic barriers to abortion services, important opportunities to tailor interventions to their diverse experiences and beliefs could be lost. This study indicates that conscientious objectors are a diverse group, unified by their concern for patients' emotional and physical well-being, but divided in terms of how to best help them and whether the fetus has priority.

"The fetus is my patient, too"—a quote from one of the moderate objectors—summarizes the way that biomedical reasoning combines with a religious definition of life to inform the way many conscientious objectors address their responsibilities toward abortion and interact with their patients. The physician who made this statement believed that fetuses are beings with rights equal to those of patients. Combining this understanding, which comes from religious teachings, with her deeply held professional ethics, she felt compelled to protect the health and well-being of the fetus. The continuation of the statement—"I'm not going to kill my patients"—reflects the physician's belief that abortion amounts to murder; this allowed her to place the rights of the fetus above those of the woman seeking care, because the fetus's life is definitely in danger, while the woman, if forced to continue her pregnancy, faces a lesser physical danger. Interestingly, this participant was willing to refer her patients, because she understood that if she did not help them access legal and safe care, they might resort to dangerous alternatives. In that case, two lives might be lost.

However, other interviewees, who expressed similarly strong views (including that abortion is murder), were unwilling to refer patients, as this would make them an "accomplice to murder." This behavior poses a serious threat to women's ability to access health care, and puts them at risk of seeking out dangerous illegal abortions, which key informants described as very readily available in Bogotá.

In contrast, most moderate objectors expressed a sense of comfort in their ability to refer; they felt secure in the knowledge that their patients would be given the care they had requested. Increased referral from conscientious objectors would be a meaningful target for intervention, and gaining a better understanding of the beliefs and practices of law-abiding and patient-respecting moderate objectors could be an area for research toward achieving this goal. By understanding what allows these objectors to feel comfortable referring and providing accurate information to patients, researchers may learn how to better encourage changes in behavior among objectors who act outside the law by refusing to refer patients, trying to change patients' minds or otherwise acting as a barrier to services.

Partial objection and its subcategories present another area for future research. Because of the short time frame available for data collection, we were able to interview only one case-by-case partial objector. Most of the gestational-age–based objectors we spoke with objected on the basis of assumed viability, though some objected to abortions performed at earlier gestational ages. A third subcategory of partial objection, technique-based partial objection, may also exist, as one interviewee described two colleagues who were willing to perform medication abortions, but not surgical abortions.

In addition to having public health implications as a potential barrier to care, partial objection presents an interesting topic for bioethical and legal investigation. Many participants refused to perform late-term procedures after a clear gestational cut-off point. In contrast, the case-by-case objector we spoke with described making decisions after interviewing the patient extensively. The case-by-case approach may result in inconsistent, subjective assessments and thus be contrary to medical ethics.[40]

The number of individuals in each group in this study reflects the researchers' time limitations, and should not be taken as indicative of the proportions of objectors who might be classified as each type. Quantitative research would be necessary to determine these proportions. Future researchers may also want to consider how differences in medical education—having attended medical school before instead of after decriminalization, for example—relate to differences in the prevalence and presentation of conscientious objection.

Limitations and Strengths

This study had several limitations. Because data collection was limited to two months, we were not able to explore in depth all of the emergent categories of objection, notably case-by-case partial objection. Moreover, the results reflect the situation in one city (Bogotá), which may not be representative of the country as a whole. Despite a small, nonrepresentative sample, the study yielded rich data, but the richness was not evenly spread across participants. Some interviewees, particularly those affiliated with universities, spoke at length after each question, offering many examples and contextual side notes; interviews with such

participants lasted as long as two hours. Most interviews, however, lasted about one hour, and the shortest, which used the same interview guide as the longest, lasted just 30 minutes. Interview locations were also highly heterogeneous, though always private. We made efforts during analysis to consider such heterogeneity.

The observed focus on a scientific or medical paradigm may have been a consequence of objectors' perceptions of the interviewer, an American graduate student studying public health and epidemiology. It would be interesting to see what, if anything, might be different about the interviews if they were conducted by a student from another discipline, such as theology or law.

This study would not have been possible without participants' willingness to engage in lengthy personal dialogue about a potentially uncomfortable topic. With few exceptions, participants were eager to talk about their views on abortion, and several referred to the interview as a "cathartic" experience. When asked to assist with snowball recruitment of participants by referring friends and colleagues, all interviewees agreed. This was a great strength of our study. The eagerness of physicians to discuss abortion-related issues in an open and honest way suggests that interventions and educational activities should include opportunities for dialogue about personal views and experiences.

Conclusion

Across the spectrum of objection, conscientious objectors described their views from a bioethical perspective in addition to a spiritual or religious one. Given that most physicians in Bogotá attended medical school when abortion was illegal, it is unsurprising that they internalized the message that abortion is dangerous or otherwise contrary to good medical practice. Assuming that medical ethics were, at least in part, taught and instilled during medical education, the medical-ethical reasoning in many interviews points to a route for intervention focused on continuing medical education and revision of medical school curricula.

Moderate objectors whose objections were primarily spiritual or religious provided arguments that could encourage extreme objectors to refer. Many moderate objectors discussed referral as an option that allows them to help save "one out of two lives." They understood that a woman who has already made the decision to abort is unlikely to change her mind just because a single physician refuses her the service, and that the mother's life is at risk if she is denied abortion, given the potential for death following an unsafe procedure. Bringing moderate and extreme objectors together for a discussion about referral might help the latter see the value of referral from a fellow Catholic's perspective.

The types of objection described in this article—extreme objection, moderate objection, and case-by-case and gestational age–based partial objection—are simplified categories intended to reflect the great diversity of perspective and approach among conscientious objectors in Bogotá. This diversity should be considered in the development of training and sensitization programming. Values clarification exercises and training around the health exception are indicated for all physicians, regardless of objector status, and should be implemented immediately by medical schools and continuing education outreach programs. One series of trainings, focused on human rights arguments for applying the health exception in a comprehensive manner, has been evaluated in Colombia and shows promise for increasing physicians' understanding of the law and respect for women's autonomy in decision-making.[41] By implementing training focused on the health exception and other topics where confusion or ignorance may be fueling unprofessional and illegal objector behavior, the impact of conscientious objection as a barrier to safe, legal abortion access could be lessened.

We sought to understand conscientious objection from the objector's perspective, in an attempt to find ways to reduce the impact of objection as a barrier to care. Colombia's courts have defined conscientious objection and delineated its limits, but our research revealed that these regulations are not being implemented and that conscientious objection is being used for denial of care. Many of our interviewees described unethical behavior, such as aggressively questioning patients, refusing to refer and providing misleading medical or legal information.

The limited nature of decriminalization opens a door for objectors to block women from accessing safe abortion services by telling them that their cases do not fit the legal criteria. Turned away without a referral and believing, incorrectly, that they do not have the right to obtain a legal abortion, these women may put their lives at risk with an unsafe procedure. Providing inaccurate legal counsel is clearly unethical, but the limited decriminalization gives objectors a false sense of control over each woman's access to care. Expanding the current law to allow abortion by choice, for any reason, would remove the gray area that allows objectors to mislead patients in this way. Allowing abortion on the basis of choice would not affect objectors' current rights, but it would reduce their power to act as barriers to safe, legal health care.

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RESUMEN

Contexto: *En 2006, la Corte Constitucional de Colombia descriminalizó parcialmente el aborto. Sin embargo, aún existen barreras al acceso, incluido el uso inapropiado de la objeción de conciencia.*

Métodos: *Con el fin de explorar la objeción de conciencia desde las perspectivas de los objetores, en 2014 se llevaron a cabo entrevistas en profundidad con 13 informantes clave y 15 médicos colombianos que se autoidentificaron como objetores de conciencia. El reclutamiento incluyó técnicas de muestreo por bola de nieve e intencional. El análisis se llevó a cabo conjuntamente con la recolección de datos y se focalizó en las actitudes, creencias y conductas de los objetores en relación con el aborto y las referencias a otros proveedores.*

Resultados: *Los objetores tienen perspectivas diversas. Fueron evidentes tres tipos de objetores: extremos, moderados y parciales. Los objetores extremos rechazaron realizar abortos o hacer referencias y, con frecuencia, sermonearon a sus pacientes; también proporcionaron información médica y legal engañosa o falsa, para evitar que las mujeres tuvieran acceso a abortos a*

los cuales legalmente tenían derecho. Los objetores moderados no realizaron abortos, pero respetaron a sus pacientes y consideraron las referencias como una forma de salvar "una de dos" vidas. Los objetores parciales realizaron algunos abortos pero rechazaron practicar otros en base a la edad gestacional o circunstancias relacionadas con cada caso. A lo largo de esta tipología, los objetores vincularon la objeción de conciencia con la ética médica y muchos describieron un deber de proteger el feto, el cual conceptualizaron como paciente.

Conclusión: *Los objetores de conciencia exhiben diversas opiniones y conductas. Algunas áreas con potencial para futuras investigaciones incluyen la identificación de factores que conducen a los objetores a referir a otros proveedores y la estimación de la prevalencia de cada tipo de objetor. Los resultados sugieren intervenciones potenciales que podrían reducir el rol de la objeción de conciencia en tanto una barrera a la hora de recibir atención.*

RÉSUMÉ

Contexte: *En 2006, le Tribunal constitutionnel de Colombie a décriminalisé partiellement l'avortement. Des obstacles d'accès, notamment l'invocation abusive de l'objection de conscience, persistent cependant.*

Méthodes: *Afin d'explorer l'objection de conscience dans la perspective des intéressés, des entretiens en profondeur ont été menés en 2014 avec 13 informateurs clés et 15 médecins colombiens qui s'étaient dits objecteurs de conscience. Le recrutement a été effectué selon les techniques d'échantillonnage en boule de neige et par choix raisonné. Parallèlement à la collecte de données, l'analyse s'est concentrée sur les attitudes, croyances et comportements des objecteurs concernant l'avortement et l'orientation vers un prestataire.*

Résultats: *Différentes perspectives expliquent la position des objecteurs. Trois grands types d'objection se sont révélés: absolue, modérée et partielle. Les objecteurs absolus refusent toute pratique de l'avortement ou orientation afférente, faisant souvent la leçon à leurs patientes; ils fournissent aussi une information médicale et légale trompeuse ou fausse, empêchant les femmes d'accéder aux procédures d'avortement auxquelles elles ont légalement droit. Les objecteurs modérés refusent de pratiquer l'avortement mais ils respectent leurs patientes et voient dans leur orientation vers un prestataire un moyen de «sauver une vie sur deux». Les objecteurs partiels pratiquent certains avortements mais en refusent d'autres en fonction de l'âge gestationnel ou de circonstances considérées au cas par cas. Dans les trois types, les objecteurs lient l'objection de conscience à l'éthique médicale. Beaucoup parlent d'une obligation de protection du fœtus, qu'ils conceptualisent tel un patient.*

Conclusion: *Les objecteurs de conscience présentent des opinions et des comportements divers. Les points potentiels de recherche future comprennent l'identification des facteurs qui amènent les objecteurs à l'orientation vers un prestataire et l'estimation de la prévalence de chaque type d'objecteur. Les résultats laissent entendre de potentielles interventions aptes à réduire le rôle de l'objection de conscience parmi les obstacles aux soins.*

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