

A critical review of conscientious objection and decriminalisation of abortion in Chile

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ABSTRACT

From 1989 through September 2017, Chile's highly restrictive abortion laws exposed women to victimisation and needlessly threatened their health, freedom and even lives. However, after decades of unsuccessful attempts to decriminalise abortion, legislation regulating pregnancy termination on three grounds was recently enacted. In the aftermath, an aggressive conservative drive designed to turn conscientious objection into a pivotal new obstacle, mounted during the congressional debate, has led to extensive, complex arguments about the validity and legitimacy of conscientious objection. This article offers a critical review of the emergence of conscientious objection and its likely policy and ethical implications. It posits the need to regulate conscientious objection through checks and balances designed to keep it from being turned into an ideological barrier meant to hinder women's access to critical healthcare.

OVERVIEW

After first arising in connection with military service,¹ conscientious objection has been increasingly expanding into healthcare contexts, notably sexual and reproductive health. Areas such as abortion, contraception, sterilisation and assisted reproductive technology are paradigmatic examples of a trend towards basing opposition on conscientious objection grounds.¹

Conceptually speaking, conscientious objection is a form of disobedience of the law.² In most health settings, it often involves practitioners who refuse to perform lawful acts or procedures that run counter to their moral conscience.³ In the Chilean sexual and reproductive health context, and especially on matters related to abortion, its underpinnings tend to be faith-based, chiefly Roman Catholic, with other grounds not as easily identifiable.³

Irrespective of definitions, conscientious objection can trigger a substantial normative conflict when it clashes with a constitutional right to timely, quality, non-discriminatory healthcare.³

This article critically analyses the probable causes of the emergence of conscientious objection as a moral concept in the Chilean health context. It also reviews the resulting policy and ethical implications following the recent debate on decriminalisation of abortion in Chile.

Below we examine various forms of conscientious objection, the Chilean system of health, the status of the abortion issue, and the associated public and congressional debates, with emphasis on so-called *institutional* and *collective* forms of objection. We also review what sets civil disobedience apart from conscientious objection.

The intent is to raise an alert about the risks involved in brandishing conscientious objection as a purely ideological barrier devoid of rational or ethical merit. We conclude that it is imperative to responsibly regulate conscientious objection to ensure that it is used both reasonably and legitimately.

CONSCIENTIOUS OBJECTION VERSUS CONSCIENTIOUS COMMITMENT

In healthcare contexts, two types of objection on grounds of conscience may be said to exist. *Negative* conscientious objection involves practitioners who decline to perform a lawful procedure,^{4,5} while *positive* objection involves practitioners whose conscience dictates the need to perform a procedure which is medically plausible or necessary, even if not allowed under the law.^{4,5}

In jurisdictions where pregnancy termination and conscientious objection are legal and regulated, a textbook example of negative objection would be a doctor's refusal to perform an abortion. Another is when abortion is a reportable crime and practitioners, feeling they cannot in good conscience compromise confidentiality and human rights, decline to do so.

A remarkable case of positive objection was the refusal of Spanish physicians to abide by Spain's Royal Decree 16/2012, which outlawed the provision of healthcare to undocumented migrants.⁵

In countries having restrictive abortion laws, a further example of positive objection are practitioners who, following the dictates of their conscience, and based on the importance of safeguarding women's health and their right to make their own sexual and reproductive choices, will willingly risk prosecution by performing safe abortions they deem necessary.

Positive conscientious objection requires the health procedures in question, whether legal or not, to be considered best medical practice.⁵ This form of objection is akin to *conscientious commitment*,⁵ the notion that ensuring patient well-being and safety at all times is a primary professional obligation.^{6,7}

Some practitioners, citing an alleged embryonic or fetal right to life over the mother's rights to health and life, assert reasons of conscience in order to refuse to provide certain services, notably abortion. Conscientious commitment, on the other hand, is the force that motivates practitioners to set aside their reservations and provide the medical services that promoting and protecting women's health requires.⁸



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In the USA and elsewhere, social and political conservatives vehemently defend negative conscientious objection stands that interfere critically with sexual and reproductive health and rights. Positive conscientious objection, in contrast, is often associated with more progressive stances.^{4,5} But if the gist of the conscientious objection argument is freedom of conscience and the right to save one's moral conscience harmless, ethically speaking it is unacceptable for either negative or positive objection to prevail over the other, as both merit identical regard.^{4,5}

THE CHILEAN SYSTEM OF HEALTH

In addition to enshrining a right to health protection, the Chilean Constitution requires the state to guarantee free, equal access to programmes designed to promote, protect and improve health. The state must ensure that such programmes are indeed offered by the public and private health systems, and guarantee everyone the right to freely choose which of the two systems to join.⁹

The Chilean health system underwent dramatic change in the late 70s, as the military dictatorship then in power essentially privatised medicine by replacing a single-payer universal health-care system with a lopsided mix of public and private components. These were the National Health Fund (FONASA), created in 1979 and currently serving about 80% of the population, and an assemblage of private, for-profit health insurance companies (ISAPREs), which presently serve about 17.5% of the population.¹⁰ Both systems are funded by mandatory 7% monthly assessments from wages and pensions.¹¹

Both are beset by major shortcomings. The public sector labours under runaway demand, inadequate outpatient services and a shortage of facilities and hospital beds. The infrastructure is often decrepit or in disrepair, and waiting lists for tests, surgery and specialist care, especially in remote areas, are often years-long. Instituciones de Salud Previsional (ISAPRE) health insurers, for their part, offer their more affluent clients top-notch clinics, cutting-edge technology and unfettered access, but tend to avoid applicants with pre-existing conditions and charge steep prices for most procedures and hospitalisations.¹¹

This is the health system that will be asked to provide the medical services arising from the recent decriminalisation of abortion. If their track record is any indication, private health insurers and facilities are likely to deny abortion services to many patients, whose only other option will be an overextended public system that already strains to meet the healthcare needs of the vast majority of Chileans.

ABORTION IN CHILE

With abortion a mostly backstreet, criminalised practice until recently, conducting related research and gathering reliable data remains a daunting task to this day. That said, recent estimates place procured abortions in Chile at some 100 000 a year.¹²

An anonymous, confidential study of 41 women recruited through social networks and snowball sampling recently probed and described some of the characteristics and consequences of illegal abortion in Chile.¹³ To ensure diversity of experiences and contexts, participants from a broad range of localities, age groups and socioeconomic backgrounds were selected. From January to July 2013, respondents took part in semistructured interviews conducted in person, by telephone or via videoconference. Most reported having used black-market misoprostol, vacuum aspiration or dilation and curettage at costs that ranged from \$200 to several thousand dollars. Among the 41 participants, one had suffered complications after an abortion abroad and five

reported having been forced to undergo a medical procedure without benefit of anaesthesia. Another two were prosecuted. One benefited from alternative measures and the other received a sentence, including a travel ban which she fought due to plans to study abroad. The researchers received indirect information about at least three other women who were reportedly coerced into performing sexual acts in exchange.¹³

This helps illustrate that restrictive laws can and will violate women's health, dignity, and sexual and reproductive rights. In addition to exposing women to victimisation and discrimination, restrictive laws make them dread being reported to the authorities and ending up behind bars. These fears often result in delays seeking medical help when complications arise, which can in turn lead to increased risks to life and health.¹

Chile legalised therapeutic abortion to protect the mother's physical or mental health as early as 1931. This lasted without interruption through August 1989, when in its dying days the military dictatorship then in power furtively enacted a ban on 'all acts intended to procure an abortion'.^{13,14} After nearly six decades of legal abortion, overnight Chile joined the notorious handful of countries that impose an absolute ban on the procedure.

While Chile returned to democratic rule in December 1989, most subsequent efforts to re-legalise abortion came to naught. Throughout this time, Chilean congressional committees considered as many as 14 different abortion bills, including 3 in 2012 alone. Conservative opposition legislators made sure that none of them ever made it to the House or Senate floor. Against this background, in January 2015, responding to strong popular support and acting on a plethora of recommendations from international human rights bodies,¹⁵ the government of President Michelle Bachelet introduced a bill to decriminalise voluntary pregnancy termination on three grounds: present or future endangerment of a woman's life; embryonic or fetal anomaly or malformation incompatible with life; and pregnancy arising from sexual violence.¹⁶

ⁱ Adolescente de 17 años permanece en riesgo vital tras aborto' In: https://www.cooperativa.cl/noticias/sociedad/salud/aborto/adolescente-de-17-anos-permanece_20-en-riesgo-vital-tras-aborto/2014-05-13/134535.html. Last visited 28 Jan 2017.

ⁱⁱ Cf. Human Rights Committee (1999), *Consideration of Reports submitted by States Parties under Article 40 of the Covenant, Concluding Observations on Chile*, 65th Session, 30 March 1999, U.N. Doc. CCPR/C/79/Add.104, Para. 15. Committee on the Elimination of Discrimination Against Women (1999), *Concluding Observations on Chile*, 21st Session, 7–25 June 1999, U.N. Doc. A/54/38/Rev.1, Paras. 228–229. Committee Against Torture (2004), *Consideration of Reports submitted by States Parties under Article 19 of the Convention, Conclusions and recommendations on Chile*, 32nd Session, 14 June 2004, U.N. Doc. CAT/C/CR/32/5. Committee on Economic, Social and Cultural Rights (2004), *Consideration of Reports submitted by States Parties under Articles 16 and 17 of the Covenant, Concluding Observations on Chile*, 33rd Session, 1 December 2004, U.N. Doc. E/C.12/1/Add.105, Paras. 25 and 52. Committee on the Elimination of Discrimination Against Women (2006), *Concluding Observations on Chile*, 36th Session, 25 August 2006, U.N. Doc. CEDAW/C/CHI/CO/4, Paras. 19–20. Human Rights Committee (2007), *Consideration of Reports submitted by States Parties under Article 40 of the Covenant, Concluding Observations on Chile*, 89th Session, 17 April 2007, U.N. Doc. CCPR/C/CHL/CO/5, Para. 8. Committee on the Rights of the Child (2007), *Consideration of Reports submitted by States Parties under Article 44 of the Convention, Concluding Observations on Chile*, 44th Session, 23 April 2007, U.N. Doc. CRC/C/CHL/CO/3, Paras. 55–56. Human Rights Committee (2014), *Concluding Observations on Chile's Sixth Periodic Report*, 13 August 2014, U.N. Doc. CCPR/C/CHL/CO/6, Para. 15. Human Rights Council (2014), *Report of the Universal Periodic Review Working Group, Chile*, 26th Session, 2 April 2014, U.N. Doc. A/HRC/26/5, Paras. 121.134 to 121.143.

The bill also elevated conscientious objection in healthcare to the status of a right. It allowed concerned physicians to register as objectors by providing prior written notice to hospital administrators. Registered objectors would not be required to perform abortions, except when no other practitioners were available to assist in life-threatening emergencies requiring immediate pregnancy termination. Otherwise, it required objectors to notify hospital administrators that a patient needed to be referred, and made referrals to non-objecting practitioners mandatory.¹⁶

CHILE: THE DEBATE ON CONSCIENTIOUS OBJECTION AND LEGALISATION OF ABORTION

Introduction of the abortion bill sparked an extensive, difficult debate on conscientious objection that involved a broad swath of actors ranging from the heads of public and private universities to scholars, top government officials, legislators, members of civil society and representatives of the medical profession.

The first salvos were fired in reaction to President Bachelet's state of the nation address on 21 May 2014, when she called on Congress and Chilean society to begin an open-minded, informed, constructive policy debate on the reality of abortion.¹⁷ Within hours the head of Chile's largest Catholic hospital network took to the media to warn that his entire institution would claim conscientious objector status and refuse to heed any resulting legislation. This initial claim of a right to *institutional* objection was later supplanted by a purported right to conscientious objection by all healthcare workers employed by institutions that adhered to a particular religious doctrine, thus giving rise to the notion of *collective* objection.^{iii iv}

A cursory look at the nature of the discussion shows that conservative groups used conscientious objection as a cudgel to fight the bill while it was being debated. It also shows that, after passage of the law, the same argument will likely be used to build an ideological wall intended to keep women from having access to legally guaranteed health services.

The recent public and parliamentary debate was marked by a high degree of polarisation that has yet to abate. During this time, Catholic hospitals joined numerous conservative legislators in mounting an uncompromising defence of an alleged right to conscientious objection by healthcare institutions and all workers directly or indirectly involved in pregnancy termination procedures.

Congress agreed only in part. As passed, the bill allowed physicians performing the procedure the right to assert objector status, but did not grant institutions a similar right. It also disallowed objection when time limits in rape cases^v are about to expire.

Once the bill was passed in Congress, conservative lawmakers applied to the Constitutional Court to rule on the constitutionality of the three grounds for abortion and the associated conscientious objection issue. After extensive public hearings that were broadcast live to an expectant nation, in a landmark decision the Court ruled that abortion on the three allowed grounds did not violate constitutional rights. That said, it expanded the right

to assert conscientious objector status to support staff present during an abortion, allowed institutions to also claim such status and removed the ban on objection when time limits in rape cases are about to lapse.^{vi 18}

The bill was signed into law on 14 September 2017.^{vii 19} In its final form, it allows both health practitioners and health institutions to claim conscientious objector status. Eligible individuals include attending physicians and other healthcare workers present during an abortion procedure. If conscientious objection is claimed, health institutions are required to immediately refer affected patients to non-objecting practitioners, either inhouse or elsewhere. The bill disallows conscientious objector claims and referrals elsewhere if emergency medical assistance is needed and requires the Ministry of Health to prepare and provide the necessary protocols for asserting objector status. These protocols must make sure that patients requiring pregnancy termination receive any required healthcare services.¹⁹

CONSCIENTIOUS OBJECTION OR CIVIL DISOBEDIENCE?

The reaction to the abortion debate raised concerns as to whether the argument is conscientious objection or some form of civil disobedience.

Some scholars define civil disobedience as a public, spontaneous, collective, non-violent act of an eminently political nature meant to impact a government's agenda or policy with a view to revising, abrogating or complying with it.²⁰ While its public and collective nature is a key element of civil disobedience, the central attribute of conscientious objection is to be a uniquely individual act which seeks no political change or revision of the law. If publicity ensues, it is often accidental, unwanted or unintended. As opposed to civil disobedience, conscientious objection is not a political tactic or strategy designed to effect change. Objectors may refuse to obey laws or rules they deem unjust and contrary to the mandates of their conscience, but do not necessarily seek to abolish them.²

Rawls, for example, writes that civil disobedience differs from other forms of defiance, such as militant action or organised resistance, in that it requires the existence of legitimate, democratic authority. Civil disobedience thus only occurs in relatively just, democratic societies whose members recognise and accept the legitimacy of the constitution. Rawls goes on to define civil disobedience as a public, non-violent and conscious political act that tries to effect changes in the law or in government programmes by appealing to the sense of fairness of the majority.²¹

To Rawls, civil disobedience is political in nature insofar as it is aimed at the majority wielding political power. It is also public, in that it takes place in the public sphere in an overt rather than hidden or secret manner. In terms of public discourse, civil disobedience is a form of the right to petition based on strongly held, conscious political beliefs. Conversely, conscientious objection is an essentially individual, private act that makes

ⁱⁱⁱ“Rector de la UC y ley de aborto: No la vamos a aplicar” In: <https://www.24horas.cl/nacional/rector-de-la-uc-y-ley-de-aborto-no-la-vamos-a-aplicar-1245107>. Last visited 30 Jan 2017.

^{iv}Rector Ignacio Sánchez: No necesitamos una ley de aborto terapéutico³. In: <https://www.cnnchile.com/noticia/2014/05/27/rector-ignacio-sanchez-no-necesitamos-una-ley-de-aborto-terapeutico>. Last visited 30 Jan 2017.

^vTwelve weeks as a rule, 14 weeks for victims aged 14 and under.

^{vi}The Constitutional Court found that allowing only medical professionals to claim conscientious objector status would arbitrarily discriminate against other participants in the procedure. It also found that preventing institutions from claiming conscientious objector status would interfere with freedom of association and corporate autonomy to act in line with their charter and mission statement.

^{vii}Law 21030 decriminalises abortion¹: when the mother's life is in danger²; when the embryo or fetus has a genetic or acquired anomaly or malformation incompatible with life; and³ when pregnancy is the result of rape, up to the first trimester as a rule, 14 weeks for victims aged 14 and under.

no appeal to the sense of fairness of the majority, takes place away from the public light, does not claim to be collective in nature and seeks no political or legal changes.^{21 22} In short, there is a clear distinction between a private act based on an objector's subjective conscience, on the one hand, and public acts of civil disobedience intended to change the legal or political status quo, on the other.²²

During the Chilean congressional debate, Catholic medical institutions argued their refusal to perform legal abortions based on a non-violent public discourse that openly targeted the decriminalisation bill. After passage, they will quite likely fight for repeal of the law. For a start, they have already warned that when it comes to the abortion law, anyone in their employ will be required to abide by the dictates of Catholic doctrine.^{viii} Taken together with protest marches and strongly worded manifestos published in the media by anti-abortion members of the medical profession, these tactics seem more akin to civil disobedience than to conscientious objection.^{ix x}

CONSCIENTIOUS OBJECTION AS A BARRIER

In 2012, after Uruguay passed abortion legislation recognising conscientious objection, some groups promptly seized on the issue to obstruct implementation. The law guaranteed women the right to make choices without interference from medical practitioners and restricted conscientious objection to the procedure itself, specifically excluding pre-abortion and postabortion care.²³ About 30% of Uruguayan obstetricians and gynaecologists were expected to claim objector status. But in the town of Salto, some 400 km northwest of Montevideo, all ob/gyns did so, launching administrative and legal actions against the law for good measure. In August 2014, a further group of Uruguayan physicians, arguing that the regulations were against the law, sought to extend objector status to all staff involved in pre-abortion and post-abortion care and to remove restrictions on their ability to influence a woman's choice.²³

The Uruguayan experience helps show that abortion opponents can and will use the conscientious objection argument to compromise women's right to safe, legal abortion, and all indications are that this will also be the case in Chile. As noted, in addition to leading the fight to assert the right of corporate entities to objector status, Chile's largest Catholic hospital network has advised its employees that they must conform to Catholic doctrine or be held accountable.

The real-life consequences remain an open question, as it is not yet known whether or how many other private health institutions will also claim objector status under the Constitutional Court decision. While private healthcare institutions account for a small share of the overall system, their refusal to provide abortion services would likely force an already overburdened public system to take up the slack.

^{viii}'Las personas que trabajan en la institución están avalando nuestra postura pro defensa de la vida'. In: <http://www.cnnchile.com/noticia/2015/02/02/rector-uc-las-personas-que-trabajan-en-la-institucion-estan-avalando-nuestra-postura-pro-defensa-de-la-vida>. Retrieved 23 Nov 2016 and 20 Aug 2017.

^{ix}'Médicos defienden en La Moneda su derecho a la objeción de conciencia'. In: http://impresa.elmercurio.com/Pages/NewsDetail.aspx?dt=2017-01-06&dtB=30-01-2017_200:00:00&PaginaId=12&bodyid=3. Last visited 30 Jan 2017.

^x'Manifestación contra proyecto de aborto en Plaza Sotomayor'. In: http://impresa.elmercurio.com/Pages/NewsDetail.aspx?dt=2016-10-13&dtB=27-03-2017_200:00:00&PaginaId=2&bodyid=3. Last visited 27 Mar 2017.

As no hard data yet exist on the prevalence of conscientious objection among Chilean healthcare workers, we cannot conjecture about its distribution across the public and private tiers of the system. Our working hypothesis, which we hope to test in a new study after the abortion law takes effect, is that the number of registered conscientious objectors will be higher than expected across both tiers. Despite recent strides, Chile has long been a socially conservative society that generally tends to condemn and stigmatise abortion. As such, the near future may well resemble the experience in Uruguay.

THE LIMITS OF CONSCIENTIOUS OBJECTION IN HEALTH CONTEXTS

As Rawls writes, the goal of a reasonably just democratic society is to maintain and foster mutual respect through principles of justice publicly recognised as fundamental to mutual cooperation among free and equal citizens.²¹ In a free society, citizens cannot be compelled to perform acts contrary to individual freedom unless the fundamental rights of others are put in jeopardy. While this definition appears to validate conscientious objection, it also imposes limits and conditions.

In fact, recognising that doctor-patient relationships are often marked by an imbalance of power which may amplify patient vulnerability, the International Federation of Gynecology and Obstetrics (FIGO)^{xi} has issued ethical guidelines on conscientious objection in sexual and reproductive health contexts. These provide that the primary duty of healthcare providers is to prevent harm by ensuring the health and well-being of all patients, with conscientious objection a secondary consideration.⁷

FIGO guidelines require obstetricians and gynaecologists to ensure that women can make free, informed and independent sexual and reproductive health choices. Importantly, practitioners declining to honour this obligation on grounds of conscience remain ethically responsible for the consequences.⁷ Since allowing conscientious objection to prevail over a patient's rights or best interest creates a conflict of interest, this must be addressed by apprising patients of all available medical and therapeutic options, including those that practitioners may disagree with on grounds of conscience. Practitioners remain under an obligation to provide timely, effective referrals to colleagues able and competent to provide the required services. In emergencies where a patient's physical or mental well-being or life is at risk, practitioners are duty-bound to perform the medically recommended procedure. FIGO guidelines further state that conscientious objectors should not be discriminated.⁷

CONCLUSIONS

While the recent adoption of abortion legislation marked a turning point for Chile, it is to be hoped that considerations related to extending conscientious objector status to all health personnel and institutions do not stand in the way of its implementation and intended effect.

Although conscientious objection finds support in freedom of conscience provisions in the Chilean Constitution, this is not and cannot be absolute. As an exception that must be kept apart

^{xi}London-based organisation bringing together professional societies of obstetricians and gynaecologists in 130 countries and territories.

from personal interests inconsistent with its moral dimension, it is essential to prevent conscientious objection from being misused as a pretext to shirk professional duties or as cover for discriminatory practices against vulnerable groups. Practitioners must regard patient well-being, life and health as a primary duty and conscientiously weigh the consequences of their acts and decisions.

Objector status is claimed in an individual, private capacity. As such, the case for conscientious objection of a purported *institutional* nature has little objective merit. Moreover, if the underlying foundation is freedom of conscience, then there are no grounds to force practitioners to conform to their employers' religious doctrines and thus no basis for the alleged existence of conscientious objection of a *collective* nature.

In sum, Chile faces an urgent and pressing need to responsibly regulate the exercise of conscientious objection, notably to preclude its misuse as an ideological barrier to critical women's healthcare, prevent infringement of women's fundamental rights, and lessen the risk of undermining women's health, especially where highly vulnerable patients are concerned.

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