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Résumé de l'article

Cet essai porte sur une question théorique susceptible de se poser dans le cadre de l'avortement tardif dans des juridictions particulièrement libérales ou très permissives, c'est-à-dire celles qui n'exigent pas que des critères soient remplis pour que la procédure soit légale. En n'établissant pas de critères limitant la pratique de l'avortement tard(if), la procédure devient légale « à la demande », du moins en principe. Cela soulève la possibilité que les professionnels de santé soient confrontés à des demandes spécifiques d'interruption de grossesse qu'ils considèrent comme moralement injustifiées, ce qui signifie que certains d'entre eux pourraient chercher à s'abstenir de pratiquer l'avortement dans de tels cas en faisant appel à la notion d'objection de conscience. La littérature existante qualifierait probablement ces appels de cas d'objection de conscience sélective. Tout en soutenant que cette notion est erronée, je suggère également qu'il est nécessaire de reconnaître un certain degré de nuance dans les positions éthiques des professionnels de la santé lorsqu'il s'agit de pratiquer des avortements à des âges gestationnels tard(ifs) dans des juridictions qui adoptent des formes de réglementation très permissives. Toutefois, étant donné que l'objection de conscience ne devrait pas être autorisée à entraver la réalisation d'interventions légalement autorisées, il existe un impératif moral de garantir l'accès et les systèmes de soins de santé doivent prendre des mesures pour assurer la réalisation de l'intervention. Bien que cela soit possible, il est peu probable que ce soit simple et cela pourrait nuire à l'établissement d'une légalisation très permissive.

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ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

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Nathan Emmerich[a]

Résumé
Cet essai porte sur une question théorique susceptible de se poser dans le cadre de l'avortement tardif dans des juridictions particulièrement libérales ou très permissives, c'est-à-dire celles qui n'exigent pas que des critères soient remplis pour que la procédure soit légale. En n'établissant pas de critères limitant la pratique de l'avortement tard(if), la procédure devient légale « à la demande », du moins en principe. Cela soulève la possibilité que les professionnels de santé soient confrontés à des demandes spécifiques d'interruption de grossesse qu'ils considèrent comme moralement injustifiées, ce qui signifie que certains d'entre eux pourraient chercher à s'abstenir de pratiquer l'avortement dans de tels cas en faisant appel à la notion d'objection de conscience. La littérature existante qualifierait probablement ces appels de cas d'objection de conscience sélective. Tout en soutenant que cette notion est erronée, je suggère également qu'il est nécessaire de reconnaître un certain degré de nuance dans les positions éthiques des professionnels de la santé lorsqu'il s'agit de pratiquer des avortements à des âges gestationnels tard(ifs) dans des juridictions qui adoptent des formes de réglementation très permissives. Toutefois, étant donné que l'objection de conscience ne devrait pas être autorisée à entraver la réalisation d'interventions légalement autorisées, il existe un impératif moral de garantir l'accès et les systèmes de soins de santé doivent prendre des mesures pour assurer la réalisation de l'intervention. Bien que cela soit possible, il est peu probable que ce soit simple et cela pourrait nuire à l'établissement d'une légalisation très permissive.

Mots-clés
avortement, avortement tardif, prestation de services, objection de conscience, refus de conscience

Abstract
This essay concerns a theoretical issue that has the potential to arise in the provision of late(r) term abortion in particularly liberal or highly permissive jurisdictions, meaning those that do not require criteria to be met if the procedure is to be lawful. By not establishing criteria that restrict the provision of late(r) term abortion the procedure is rendered lawful "on demand", at least in principle. This raises the possibility that healthcare professionals may encounter specific requests for terminations that they consider morally unjustified, meaning that some might seek to "opt-out" of provision in such cases by appealing to the notion of conscientious objection. The existing literature would likely frame such appeals to be instances of selective conscientious objection. Whilst I argue that this notion is flawed, I also suggest that there is a need to recognise a degree of nuance in the ethical positions held by healthcare professionals when it comes to the provision of abortion at late(r) gestational (st)ages in jurisdictions that adopt highly permissive forms of regulation. However, given that conscientious objection should not be permitted to obstruct provision of legally permitted interventions, there is a moral imperative to ensure access, and healthcare systems must take steps to ensure provision. Whilst it may be possible, it is unlikely to be simple, and it may auger against establishing legalisation that is highly permissive.

Keywords
abortion, late term abortion, service provision, conscientious objection, conscientious refusal

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INTRODUCTION

This essay is not concerned with the ethics of abortion per se and whilst it is cognisant of a range of reasonably defensible and well-established positions on the issue, these are not subject to critical examination. Rather, the issue to be addressed is whether there might be a case for recognising an elevated degree of ethical nuance when it comes to questions of conscientious objection in relation to the provision of late(r) term abortion. More specifically, this issue is examined in the context of a particularly liberal or highly permissive approach to late(r) term abortion, by which I mean legislation that does not restrict access to the procedure.[1] Whilst it may not always be the case in practice, it is generally assumed that those who provide a particular intervention should do so in accordance with the relevant clinical and legal frameworks and that those who wish to conscientiously object should "opt-out" of provision entirely.[2] This might be thought of as an "all or nothing" of "absolute" approach to conscientious objection; healthcare professionals either provide the service in accordance with the law or they do

[1] The meanings of the terms 'early', 'earlier', 'late' and 'late(r)' are imprecise. Whilst there is a need to draw a distinction there is no rationale that can provide a precise point of differentiation. One can find various legislative frameworks that draw the line between the 16th and 24th week of pregnancy and, for the purposes of this essay, I take it that late(r) term abortion occurs after the 20th week of pregnancy whilst those that occur at late(r) stages occur after this point. This usage may differ from the way the terms are used in other contexts. However, as noted below, the distinction arguably maps onto the uncertain point at which foetal sentience emerges as well as viability, the point at which it becomes increasingly realistic to think that the foetus can survive as an independent organism, albeit with a particularly high level of medical intervention. It also maps onto the practicalities of abortion provision. Early or earlier abortion is generally provided via medical or surgical means by general practitioners or dedicated clinics, of the type run by Marie Stopes, British Pregnancy Advisory Service and so forth. Late or late(r) term abortion is generally provided by specialist obstetricians in hospitals. As will be made clear, that this is the case is not irrelevant to the conclusions I draw.

[2] There is some evidence that healthcare professionals do not act in this way. I take it that it is problematic that they do so and that they ought to behave in the way(s) described (1,2).

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not provide the service at all.[3] This paper examines the case for a more "selective" approach to conscientious objection in relation to late(r) term abortion.

To my knowledge, this is not something that has previously been discussed in the bioethical literature. This is likely because the majority of jurisdictions establish criteria that must be meet if an abortion is to be lawful at late(r) gestational stages.[4] It therefore seems reasonable to assume that the healthcare professionals involved in provision consider it to be morally permissible in the circumstances outlined in law; if they did not, they would presumably opt out of any and all involvement. As this suggests, very few jurisdictions regulate late(r) term abortion in the permissive way that gives rise to the issue I seek to discuss.[5] Furthermore, there are significant extra-legal obstacles which generally mean that women who wish to end their pregnancies in the absence of the kind of criteria ordinarily outlined in law are unable to do so.[6] Nevertheless, in jurisdictions that do not require specific criteria to be met for an abortion to be lawful at any gestational stage then it seems reasonable to assume that at least some providers will have moral concerns regarding provision of late(r) term abortion absent the kind of criteria commonly established in other jurisdictions. Furthermore, maintaining an all or nothing approach to conscientious objection in such contexts may have significant implications for service provision. This paper calls into question the "all or nothing" approach to conscientious objection. If a more selective approach might be justified in relation to late(r) term abortion in highly permissive jurisdictions, then perhaps we should rethink the way conscientious objection is understood more generally.

The essay proceeds as follows. First, I discuss some basic aspects of the legal regulation of abortion and sketch what I refer to as the "highly permissive" approach to the regulation of abortion provision at late(r) gestational (st)ages. This sets the scene for a discussion of this paper's substantive concern, the possibility that a more selective approach to conscientious objection in relation to late(r) term abortion might be justified in jurisdictions that promulgate laws of the kind identified. Part of my purpose in this essay is to shed light on the notion of conscientious objection as I see it, aspects of which do not sit well with contemporary bioethical accounts.[7] In the conclusion I examine the implications of the case I have set out with a specific focus on the regulation of abortion at late(r) gestational (st)ages.

Before proceeding any further it is worth noting some general points regarding abortion and its provision. In the first instance, we might acknowledge that late(r) term abortions occur far less often than earlier term abortion and that those who have abortions at late(r) gestational stages are generally not doing so because they no longer wish to have a(nother) child, something that not uncommonly motivates those seeking an early abortion.[8] Furthermore, advances in foetal diagnosis and, therefore, the provision of information that might prompt a decision to terminate a pregnancy on the part of someone who wishes to have a child, means that if an abortion is desired it can be done at earlier gestational stages than might have been the case in the recent past. As such, the best way to ensure low rates of late(r) term abortions is to ensure that the provision of antenatal services, including abortion, is both comprehensive and accessible at early stages of pregnancy.

Regardless of such efforts, it will nevertheless remain the case that the provision of abortion at late(r) stages of pregnancy will need to be maintained for the foreseeable future. Whilst it is not uncommon to encounter claims that no one ends a pregnancy at any stage without good reason (4), it is also true to say that sometimes that reason is simply no longer wishing to be pregnant. Of course, this raises the question of what counts as a good (enough) reason and if it is the case that simply no longer wishing to be pregnant can be considered sufficient justification regardless of gestational age.[9] However, whilst one can take legal prohibitions to communicate a degree of negative moral evaluation, an absence of such prohibitions ought not be taken to indicate ethical approval. We might therefore consider whose ethical perspective should be considered relevant to

[3] That conscientious objection should lead one to an "all or nothing" stance with regard to whatever is being found objectionable stems from the way conscientious objection to military drafts was first articulated in the early part of the 20th century. Those who sought to be recognised as conscientious objectors to military service were required to object to war — or the use of violence — *per se*, and not to the specific case (e.g., World War I or, subsequently, the conflict in Vietnam). In discussions of conscientious objection in healthcare this point has gone largely unaddressed; it has not been explicitly endorsed or rejected. Nevertheless, it seems to play a largely unacknowledged role, something this essay implicitly calls into question. As Cowley says in a paper on selective conscientious objection "Most discussions of conscientious objection in healthcare assume that the objection is universal: a doctor objects to all abortions" and that "it seems that any GP ready to invoke the words 'conscientious objection' will be expected — by colleagues, patients and employers — to harbour a universal objection. That expectation is mirrored in the philosophical and legal literature on the topic." (3)

[4] These criteria are commonly: a high risk of death or significant threat to health (including mental health) if a pregnancy is not discontinued; a pregnancy resulting from rape or incest; or a foetal diagnosis of fatal abnormalities or a life limiting disability.

[5] The matter(s) raised in this paper are, therefore, largely theoretical. Nevertheless, they are worth discussing solely on the basis that some argue for kind arrangements that would give rise to these kinds of issues (cf. 4). Furthermore, one finds that even in jurisdictions that adopt permissive approaches to late(r) term abortion, access to late(r) term abortion is nonetheless restricted such that it is not available "on demand" or without the kinds of reasons ordinarily written into law being present.

[6] This should be a source of concern. Whilst I do not defend the point in detail, I take the view that if those elected to make the law have elected not to restrict late(r) term abortion then those who are unelected should not be able to use other means to do so. It is in this context that the question of a more nuanced or selective form of conscientious objection to late(r) term abortion has the potential to arise.

[7] Indeed, my view of conscientious objection differs from established bioethical accounts. Existing literature has a tendency to focus on individual actors, their actions and the integrity of their moral conscience. I consider regulation that establishes and circumscribed the 'right' to conscientiously object to be the basis of any such act. See my essay: Conscientious Practice and Conscientious Objection in Healthcare (under review).

[8] I do not wish to suggest that women seeking an abortion at earlier gestational stages are not motivated by a complex array of reasons, only that these reasons lead women to conclude that they do not want to have a child (at this point in time) and so they seek a termination. Equally, those who continue a pregnancy into the second and third trimester do so because they have concluded that they wish to have a child. It is exceedingly rare for someone to seek a late(r) term abortion because they have simply changed their mind and decided that they do not want to have a child. Late(r) term abortions tend to be motivated by some other factor, such as a foetal diagnosis or the fact that continuing the pregnancy will pose a significant risk to their health. Of course, the fact that a majority of jurisdictions require certain criteria must be met if late(r) term abortion is to be lawfully provided is not irrelevant. However, there is no reason to suppose that it is playing a determinative role with regard to why someone might seek to terminate a pregnancy.

[9] Kendal has recently argued all abortions are medically necessary on this basis (5).

the question of late(r) term abortion, either in general or in the particular case. If an agnostic position is maintained in law, then it would seem the only relevant ethical perspective(s) are those directly involved. That this is the case is, precisely, what gives rise to debates about conscientious objection, both in general and in the context of healthcare.

THE LEGAL REGULATION AND ETHICAL PROVISION OF LATE(R) TERM ABORTION

Whilst it is not without ambiguity, there is some reason to distinguish between 'early' or 'earlier' and 'late' or 'late(r)' term abortion. Certainly, differing clinical techniques are required to terminate a pregnancy at differing gestational stages. However, from an ethical perspective, such matters are largely irrelevant. What would seem to be of primary concern is the moral status of the developing foetus, at least initially. As this paper is focused on the provision of abortion at late(r) gestational stages, it is assumed that early term abortion is ethically permissible or, at least, that it is appropriate for legal frameworks governing the provision of abortion at earlier stages of pregnancy not to limit the procedure.[10] I therefore proceed on the basis that any ethical concerns about the provision of abortion at early — or earlier — stages of pregnancy should be devolved to those involved and that the law should be shaped accordingly.[11]

This paper also assumes that it is defensible to suppose that some (additional) degree of moral significance accumulates in or attaches to the foetus during or at some (unclear) point in its gestation. This would seem to be implied by legislation that limits the provision of late(r) term abortion by establishing criteria that must be met if the intervention is to be lawfully performed. The relevant UK legislation — the Abortion Act (1967) — is a clear example of this type. Equally, this essay also assumes that it is defensible not to establish any such criteria for the lawful provision of late(r) term abortion and, in so doing, for the law to maintain the kind of agnostic position regarding the ethics of abortion at late(r) gestational ages that one generally finds in law relating to abortion in earlier gestational (st)ages. Similarly, a jurisdiction could elect not to formally legislate abortion in any way meaning that, like any other intervention, it would be regulated by existing health law.[12] I am not aware of any jurisdictions that have pursued this kind of option and although some have adopted a highly permissive approach of the kind sketched here, they are few in number.[13]

Regardless of the way the law on abortion is drawn in a particular jurisdiction, legislation commonly includes clauses permitting healthcare professionals to conscientiously object.[14] Such clauses enable those whose clinical duties would directly involve them in the provision of the intervention to opt out of being involved. This "right" is granted on the basis that it would be wrong to compel those who consider abortion to be morally impermissible to be providers of the service. The obviously corollary is that those who do not participate in the provision of abortion are expected to do so because they consider doing so to be morally wrong and not because they simply prefer not to be involved.[15] Healthcare professionals who conscientiously object to abortion are not required to substantiate or register their views, not least because doing so would be difficult to implement, it is unlikely to achieve all that much and may have unintended consequences (7,8). However, whether as a matter of law or professional regulation, they are generally required to refer patients who may be considering terminating their pregnancy to another healthcare provider who does not morally object to the intervention. Further discussion of such points can be found in the extensive literature on conscientious objection in healthcare (cf. 9-13). Whist it would not be accurate to suggest that the views advanced are entirely uniform on such matters, I take it that this brief sketch indicates the way in which conscientious objection to the provision of abortion is generally understood and meant to work in practice. Recognition of the right to conscientiously object to the provision of abortion seeks to accommodate the moral perspectives of some healthcare professionals whilst also ensuring that access to lawful medical services is not subject to significant obstruction.

The issue addressed in this essay concerns the possibility of healthcare professionals seeking to conscientiously object to some — but not all — late(r) term abortions when practicing in highly permissive jurisdictions. Unless they practice in one of the few jurisdictions that do not permit healthcare professionals to conscientiously object, it is certainly possible for those whose professional duties would ordinarily involve them in the provision of late(r) term abortion to opt out of doing so. Therefore, there is some concern that some — and perhaps a majority — of providers may well cease their involvement in provision if a more nuanced approach is not facilitated in the relevant jurisdictions. This would be likely to affect the availability of services. A more nuanced approach would, in effect, permit individual healthcare professionals to conscientiously object on what might be thought of as a "selective" basis. In short, they would be able to opt out of service provision in particular cases or, to anticipate the discussion presented in the following section, they would limit their involvement in service provision to cases that meet certain conditions.

[10] Clearly some would demur from this view. However, it seems safe to presume that those who consider early abortion ethically impermissible think similarly with regard to late(r) term abortion, indicating that the issue raised in this paper is of no concern. However else the phrase "selective conscientious objection" might be understood, it should be understood to mean that an undertaking is sometimes thought morally permissible and sometimes thought morally impermissible.

[11] Of course, how these devolved concerns should play out for the individuals involved will differ depending on how they are positioned. A pregnant person is positioned such that they are free to determine their own ethical perspective on abortion, both in general and in the particular case. The healthcare professional is positioned such that they may only take a general view and, on that basis, either provide the relevant service to their patients, or opt-out of doing so entirely. This essay arguably results from transferring this kind of thinking to abortion at late(r) gestational (st)ages.

[12] Dwyer et al have recently argued for this kind of approach. They do not consider the implications for conscientious objection as outlined here (4).

[13] It is worth pointing out that even for those that have established permissive legislation with regards to late(r) term abortion, this does not mean that the intervention is available 'on demand.' Extra-legal barriers often mean that only those who have clear medical reasons for seeking a termination at a late(r) stage in their pregnancy are positioned to access the intervention.

[14] There are a few exceptions and there is no established right to conscientiously object to the provision of abortion in Sweden, Finland, Bulgaria, the Czech Republic and Iceland (6).

[15] Termed 'convenient objection', this seems to occur despite such behaviour clearly being in conflict with the level of professionalism expected of healthcare providers (2).

Given that the legal restrictions put in place in jurisdictions like the UK can be taken to reflect the legitimacy of supposing late(r) term abortions require justification beyond the individual's decision to terminate their pregnancy, it seems reasonable to think some healthcare professionals might express a similar view. They might, for example, consider late(r) term abortion to only be permissible in certain circumstances, such as: where continued pregnancy presents a high risk of death or significant threat to health; or where a pregnancy results from rape or incest; or where a foetal diagnosis of fatal abnormalities or a life limiting disability has been established. Absent such criteria being met, healthcare professionals might appeal to the notion of conscientious objection and, in so doing, seek to "selectively" restrict their involvement in the provision of late(r) term abortion.

CONSCIENTIOUS OBJECTION IN THE CONTEXT LATE(R) TERM ABORTION

If it is the case that the ethical perspectives held by some healthcare professionals can be thought of as reflecting the way abortion law is currently drawn in jurisdictions like the UK then, when practicing in jurisdictions with highly permissive legislation, it is possible that they will encounter requests for late(r) term abortion that they consider morally wrong. It therefore seems probable that they will appeal to the notion of conscientious objection as, on the face of it, this will permit them to opt-out of being involved in these cases. However, healthcare professionals who conscientiously object to particular interventions are ordinarily expected to opt out of provision entirely. This expectation reflects certain presuppositions about the universal or absolute rejection of the undertaking in question on ethical grounds. In what follows, I will have more to say about this. However, for the time being it is sufficient to note that if healthcare professionals are to appeal to the notion of conscientious objection in order to opt out of providing some, but not other, abortions at late(r) stages of pregnancy then it would appear that they are seeking to engage in a *selective* or *individualised* form of conscientious objection (3,14,15).

What might be meant by terming specific claims to conscientiously object selective, individual or individualised is far from clear. There is a relatively limited (bioethical) literature on the notion, and it will not be possible to clarify matters entirely. Instead, a few comments must suffice. Cowley has recently suggested that because they are "focused on the patient, and on her reasons (or on her perceived lack of good reasons) for seeking the abortion" selective conscientious objections are "unpredictable" (3). This seems to suggest that healthcare professionals should be permitted to evaluate their patient's reasoning from a moral perspective and determine whether or not they are willing to provide an intervention on that basis. On the face of it this would seem to be a clear case of (moral) paternalism. Healthcare is a public service and, presuming it reflects an autonomous decision, lawful requests for clinically justified treatment, including abortion, should be fulfilled.[16] The fact that a patient may have a poor reason for their decision should not be considered reasonable motivation for conscientious objection, not least because making such judgements is not something that falls within the scope of professional practice.

Such a stance would seem to suggest that healthcare professionals should not be able to conscientiously object to some requests for late(r) term abortions and not others because doing so would seem to require a moral evaluation of the patient's reasons or reasoning. As presented by Cowley, selective conscientious objection would seem to be incompatible with professional standards and therefore impermissible. Nevertheless, we might consider if this is the only way to think about what is going on. There is a distinction between determining that an individual has a bad, or insufficiently good, reason for requesting the intervention, and considering abortion impermissible unless certain criteria are in place. Whilst the law may remain agnostic on the ethics of late(r) term abortion one can hardly expect the same of all healthcare professionals involved in its provision. As such the question of "selective" conscientious objection becomes a matter of a healthcare professional's moral framework vis-à-vis late(r) term abortion and, subsequently, whether it is permissible for them to configure their practice in accordance with it. In this view, selective conscientious objection is not a matter of judging individuals and their reasons but of holding an ethical position that is more nuanced than the position established in law.

If it is the case that healthcare professionals can conscientiously object to late(r) term abortion on this kind of basis, we should also consider if they might do similarly in the context of earlier term abortion, if only to fully understand why they should not be able to do so. In this context, my response concerns the aforementioned supposition that conscientious objection should be motivated by a moral position that is universal or absolute. However, it seems reasonably clear that many healthcare professionals who conscientiously object to abortion and therefore opt-out of service provision do not consider the procedure universally wrong. Few could consider terminating a pregnancy unjustified when it is the only way to preserve the life of the pregnant individual, and when the alternative is the death of both patient and foetus. Equally, few would reject abortion when continued pregnancy will result in a short life of suffering for the resulting infant or neonate.

Such eventualities are, of course, exceedingly rare and the majority of patients seeking an abortion at earlier stages of pregnancy are obviously not motivated by such reasons, knowledge of which only tends to become known in the late(r) stages of pregnancy. Such points indicate that there would be no purpose in permitting those positioned to provide abortion at earlier stages of pregnancy to establish rationales for (non-)provision. This contrasts with the provision of late(r) term abortion, where almost all patients are being offered a termination because continued pregnancy would present a threat to their life or health, or because they have been given some kind of foetal diagnosis.

[16] It is worth pointing out that whilst abortion might be recommended for clinical reasons, such as in cases where continued pregnancy poses serious risk to the patients' health, in the absence of such factors it is enough that the individual concerned has decided to end her pregnancy.

In the light of such discussion, we should recognise that requiring those who conscientiously object to abortion to opt out of service provision entirely does not result from the fact that they reject the intervention universally or that the idea of conscientious objection supposes that they do so. Rather, it is the result of more pragmatic concerns. In the context of the provision of abortions at earlier gestational stages it would simply be impractical to facilitate a more nuanced approach. Doing so would only delay patient access to the intervention and likely result in them being unnecessarily exposed to the personal moral judgements of those who, on the basis of their commitment to professionalism, are meant to avoid doing so.[17] Nevertheless, if healthcare professionals are to be permitted to conscientiously object to providing late(r) term abortions that are not justified by stipulated criteria, a number of questions remain to be considered, including: whether or not many of those involved in the provision of late(r) term abortion will seek to conscientiously object; the impact this might have on the availability of service to the relatively small number of individuals who seek the intervention and are not motivated by the standard criteria that commonly render the procedure lawful; and if there is a shift in the moral perspective that underpins claims to conscientious objection to late(r) as compared to earlier term abortion.

The first two of these questions are, quite obviously, empirical matters and it is difficult to offer much in the way of a response. It is arguably the case that even where provision is not subject to significant legal constraint, access to late(r) term abortion is commonly subject to a range of structural barriers, including an absence of clear (self) referral pathways. This is something that ought to change regardless of the issue at hand. It likely continues — or, at least, goes relatively unchallenged — precisely because very few women seek to terminate pregnancy at late(r) gestational stages without there being a clear clinical reason for them to do so. When such reasons exist, they will already be under the care of those who are able to provide a referral or who are themselves providers of the relevant service. Equally, it is also likely to be related to a certain degree of moral discomfort with abortion at late(r) gestational ages. It is not obvious what this might mean when it comes to how many providers of late(r) term abortion working in highly liberal jurisdictions will seek to conscientiously object.

The third point can be addressed more directly. On the face of it there would seem to be a morally relevant distinction between earlier and later term abortion, specifically the emergence and development of sentience in the foetus. The point at which this might occur is, of course, uncertain. Current thinking would suggest it likely arises around the 20th week of a pregnancy. However, not only is this a matter of some speculation, what foetal sentience might amount to from a phenomenological perspective before, after and at this point is also unclear. As such the degree of moral significance that might be thought to result is also unclear. Nevertheless, it is certainly evident that some consider it to be morally relevant and to lie at — if not clearly mark — the juncture between earlier and late(r) term abortion. It therefore seems reasonable to suppose that at least some would take the view that late(r) term abortions require justification of a sort that goes beyond the patient's desire not to be pregnant. Indeed, this position is arguably reflected in legislation that distinguishes between abortion at earlier and later gestational ages, where the former is permitted "on demand" but the latter requires certain criteria to be met if it is to be performed lawfully.

It would seem, then, that there is some basis for a nuanced or selective form of conscientious objection on the part of healthcare professionals involved in the provision of late(r) term abortion when situated within highly permissive jurisdictions. However, if this is to be put into practice, healthcare professionals should establish the parameters of their moral perspective before seeking accommodation for their views. This clearly implies that they must give full and proper consideration to circumstances under which they consider the provision of late(r) term abortion to be morally (im)permissible and reflect on how best to structure their practice in a manner consistent with their conclusions. Given the responsibilities involved in good medical practice, this is not something that healthcare professionals can do without reference to professional guidelines, their employers or their colleagues, both notional and specific. Indeed, this line of thinking quite clearly raises a host of practical and pragmatic issues when it comes to accommodating the various ethical positions that healthcare professionals might embrace. All those involved, including those who would seek to conscientiously object, have a responsibility to consider such matters and to determine a way forward that meets the needs of all those involved or (potentially) affected.

If it were not the case that very few women seek to have an abortion at late(r) stages of pregnancy, such concerns might be taken to mean that accommodating conscientious objections of this sort was simply impractical to the point of being unworkable. In my view such matters ought to be taken seriously. The conscientious objections of healthcare professionals should not be permitted to significantly affect service provision and so refusing to accommodate them remains an option.[18] However, as most will be of the kind permitted under legislation that has commonly been adopted, it is likely that the majority of cases will not be considered objectionable. Furthermore, as long as some healthcare professionals feel able to provide abortion at late(r) gestational stages without restriction, then it should be possible to ensure provision if efforts are made to ensure an appropriate institutional policy is put in place.

[17] For example, it is not appropriate for a patient seeking to terminate a pregnancy at an early stage to be subject to tests to establish whether they meet a potential provider's personal criteria. This may change were it the case that foetal genetic testing becomes available an early stage in pregnancy. A healthcare professional caring for pregnant women might take the view that early medical abortion must meet certain criteria if it is to be justified and try to establish a claim to conscientiously object. Whether such a claim can be substantiated would be a matter for debate along the lines set forth in this paper. Similarly, pragmatic consideration of the circumstances relating to the provision of care would be central to whether such a claim might be accommodated.

[18] If the result is that too few individuals are willing to practice in a particular field to the point where services are affected, then it may be that the legislation itself should be revisited. Normative structures — such as legislation, professional regulations, guidelines and governance processes more generally — are unavoidably political. If those affected by such structures find that they are unable to practice within its dictates, then it lacks a necessary degree of legitimacy and should likely be revisited. I made a similar point in my essay *Ought Conscientious Refusals to Implement Reverse Triage Decisions Be Accommodated?* (17).

Nevertheless, one might question if the need to make such arrangements counts against establishing legislation that adopts a highly permissive approach to late(r) term abortion. In the context of earlier term abortion and the kind of highly restrictive legislation that some American States have promulgated following the Supreme court's decision in *Dobbs v Jackson*, Shachar, Baruch and King have argued that it is the responsibility of legislators to recognise and clearly define circumstances in which provision is medically necessary and should therefore be legal (16). A similar point might be applied to late(r) term abortion. Whilst abstaining from establishing such criteria and devolving any moral concerns to the patient and those involved may be consistent with progressive feminist politics, the ensuing complications of the kind sketched in this paper may mean that some degree of regulation, in the form of legislative restrictions, is warranted.

CONCLUSION

This essay has argued that in jurisdictions that adopt a highly permissive approach to the regulation of late(r) term abortion there may be a case to be made for accepting selective or nuanced claims to conscientiously object. I have also pointed out that conscientious objection should not be permitted to obstruct — or significantly impede — service delivery, meaning that if conscientious objection is to be permitted, steps should be taken to ensure that patients are able to access lawful healthcare interventions as appropriate. Whether it is possible to address the practical issues that will arise in places where individuals wish to conscientiously object to some late(r) term abortions remains to be seen. One would hope that it is the case. However, it may not be, and it may therefore be that we should not establish a right to conscientiously object to late(r) term abortions in a selective or nuanced way. Alternatively, it may be that adopting a highly permissive approach to the legal regulation of abortion at late(r) gestational (st)ages is misguided.

Such questions directly result from a legislative approach that does not constrain late(r) term abortion, an intervention on which a range of moral perspectives might be adopted. This has the potential to place healthcare professionals involved in caring for pregnant patients in a morally complex position. Whilst healthcare professionals (or, perhaps more accurately, medical doctors) can refuse to provide interventions that they do not consider clinically justified without facing professional sanction, doing similarly on moral grounds means seeking to conscientiously object. If this is to be an option there is a need to ensure patients are professionally cared for, meaning that an individual's ability to conscientiously object relies on other healthcare professionals being willing to provide the relevant service, and on local arrangements being put in place to appropriately manage the delivery. Thus, healthcare providers — and, for that matter, all those who are involved in both the provision and broader organisation of services — will be placed in the unusual position of having to manage a complex moral situation rather than operate within established ethico-legal parameters.[19] One might consider this an unintended consequence of highly permissive approaches to legislation.

This issue was effectively, if implicitly, acknowledged in a recent essay arguing against the need for any abortion-specific legislation (4). There the somewhat naive or, perhaps, overly idealistic response to moral concerns about the provision of late(r) term abortion is to say that provision should occur "when the woman and her health care team decide it is necessary."[20] Since agreement may not always be forthcoming, unless what these authors mean by necessity is met by a patient who insists on ending her pregnancy regardless of her reasoning[21] — something that would undermine the idea that agreement is required — then this would seem to permit healthcare professionals to restrict provision on the basis of their moral perspective and, therefore, to sanction an inappropriate degree of (medical) paternalism. The fact that a government elects not to restrict an intervention as a matter of law does not equate to ethical approval, either in general or the specific case. However, to ethically sanction or refuse requests for such interventions is not something healthcare professionals should be either asked or permitted to do.

I have, of course, argued that it is permissible for healthcare professionals to do similarly and to provide or conscientiously object on that basis. It is also the case that patients considering a late(r) term abortion would do well to consider the moral dimension of the issue for themselves. Nevertheless, the fact that clinicians might configure their involvement in late(r) term abortion in accordance with their general moral views does not mean that it is permissible for them to constrain the moral choices of patients. Healthcare professionals should not be making moral judgements on a case-by-case basis. If no criteria are required to be met if late(r) term abortion is to be lawful, then the only thing of relevance is the patient's decision to end their pregnancy. As such, there is a need to ensure services can and will be provided, if and when such circumstances arise. If that cannot be done, then there may be a need to reconsider the adoption of a highly permissive approach to late(r) term abortion.

[19] It is arguably not uncommon for healthcare professionals to require professionals to manage moral concerns as part of clinical practice. However, this differs from the kind of management required to accommodate the conscientious objection.
[20] The naivety lies in thinking that there will never be a need to ensure provision when, contra their healthcare teams view, a patient persists in their decision to end their pregnancy (4).
[21] As previously noted, Kendal argues that this is the case (5).

POSTSCRIPT

It has long been on my mind to write a paper on the difficulties that might potentially arise if a highly permissive approach to abortion at any stage of pregnancy is established in law. However, the possibility that doing so might negatively affect the provision of late(r) term abortion — either in general or in the specific jurisdictions that have adopted this approach — has caused significant delay as I have tried to think through how best to do so. This paper can and should be taken as entailing the rejection of certain practices — such as Termination Review Committees — that have arguably resulted from the moral perspectives of those who are practicing in the context of highly permissive legislation not being given due consideration and being misdirected as a result (18).

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