Secular state, conscientious objection and public health policies

Estado laico, objeção de consciência e políticas de saúde

Estado laico, la objeción de conciencia y las políticas de salud

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Secularity matters to health policies. Secularity is more than religious neutrality in government affairs – it is a condition for governability in a plural and democratic state. In health, it matters where government leaders seek inspiration for their official acts, whether in academic knowledge or in religions. The post-modern concern over the statute of truth is insufficient to strip science of its value for public policymaking. Thus, not everything in the moral field is fair grounds for health practices in duties to the citizens of a secular state.

My argument is simple – religion should be a matter of private ethics, and public policies should not be based on religious mystics concerning welfare. Therefore, psychotherapy aimed at reversing homosexuality is not good scientific practice, but quackery. Likewise, banning embryonic stem cell research with the pretense of safeguarding the frozen embryo's right to life is religious dogma and not a serious discussion on the morphology of human genesis. Science or quackery, research or dogma, are not adjectives to qualify practices, but political nouns.

It is with a political noun that I intend to provoke the principal expression of the Brazilian state's weak secularity in health – the growing concern over conscientious objection as a device. What does conscientious objection mean? In this case it is health professionals' denial, on purported moral grounds, of their duty to provide care. The most common scenario is that of abortion: physicians, nurses, social workers, or psychologists, each according to their own knowledge and power systems, refuse to assist a woman who wishes to undergo an abortion. This is not new today, when the Congressional Committee on Human Rights is chaired by a fundamentalist pastor. Severina's story took place in 2004, a few days after a preliminary injunction that allowed abortion in cases of anencephaly was overruled by the Brazilian Supreme Court [1,2]. Even with a court authorization in force, the anesthetists at the hospital where the patient was referred for a legal abortion refused to assist her – claiming religious grounds.

Severina was Catholic and failed to understand why a court ruling was not enough to guarantee her right to the abortion. Her proof of identity was her worker's card – an existential imprint of her class and origin. She waited for hours: carrying a non-viable fetus, was incapable of convincing those who had the duty to assist her. Her potential caregivers claimed they were in moral suffering: the abortion was a grave threat to their feeling of religious integrity. Thus, their refusal was supposedly a legitimate form of objection. No anesthetist at the hospital stepped up to relieve her pain. Severina waited and trekked from one hospital to another. She was finally as-

 http://dx.doi.org/10.1590/0102-311XPE010913

sisted by a volunteer anesthetist from a private clinic, to perform an induced abortion in a public hospital.

Conscientious objection can be interpreted as a fundamental right or as protection of a sentiment. In terms of public health policies, my provocation is to understand conscientious objection as a device for protecting sentiments, and can be guaranteed by administrative measures for internal accommodation in health services. Yes, I dare to re-describe the device of conscientious objection as an adjustment of protection, but not as an absolute right when it threatens health needs. I explain: I wish to believe that we should all have the inalienable right to civil disobedience – resisting conscription into wars is a example. We want a state that protects our individual rights, whether to profess beliefs or to march for freedoms. But it does not suffice to declare freedom of thought and expression in order for conscientious objection to also be claimed as an absolute and universal right – at least in healthcare.

If that were the case, public healthcare services would suffer a dire threat from the growing juxtaposition of religions and rights in Brazilian politics. From administrative staff to physicians and nurses, all would be protected by the Constitutional principle of freedom of conscience when renouncing their professional duties, whether to complete a hospital admissions form, perform an abortion, or simply to help clean a patient. The possibilities are exponential and intimidating for whoever seeks to allay afflictions, fears, or pain in healthcare services. Such is the case with a woman who has been raped when she reaches the critical route to abortion in public services. But it could pertain equally to other situations in which moralities and duties cross paths with rights and needs.

Some claim that doctors cannot be conscientious objectors. The refusal to provide care would be inconsistent with the very nature of the medical profession [3]. I see this as a view based more on ideal professional types than on real people, whose moral life is both a choice and a legacy. Rather than confronting physicians' beliefs and weaknesses, the solution is to organize the tense interface between dogmas, sentiments, and health needs. Individuals are free to become doctors. An abortion is exclusively a medical act, and it is prohibited for nurses or midwives to perform one, even in remote areas of the country. Physicians are free to profess their moral beliefs, religious or otherwise. A woman is free to decide whether to have an abortion if she has been raped. This is the tense scenario involving suffering and rights: women want to have the right to abortion and do not want to be assisted by physicians in suffering.

There are at least two approaches for dealing with the issue of conscientious objection in a secular framework of public health policies, that is, where religious beliefs are not absolute, nor do they define the political pact. The first wagers that administrative adjustments in health services are capable of harmonizing needs and sentiments. In biomedical language, there would be measures for regulation and prevention: (a) organizing hospital work shifts without conscientious objectors and (b) non-participation by conscientious objectors in practices contrary to their conscience. The Pérola Byington Hospital in São Paulo, one of the referral centers in Brazil for legal abortion, was daring in a preventive measure – the recent admissions process for hiring a psychologist for the hospital's staff was explicit in relation to this specific future government employee's job description, namely, being assigned to the hospital's legal abortion service. But the second approach interests me more here: it is necessary to remove the conscientious objection issue from the religious sphere and situate it in the field of relations of power and domination.

A secular state believes in the sincerity of its citizens' beliefs. Physicians who claim conscientious objection due to religious suffering vis-à-vis caring for the sexual health of a homosexual man or a female rape victim should be heard in terms of their pain. Caring for their anguish is not the same as guaranteeing civil disobedience in their duties. The juxtaposition of suffering and the right to conscientious objection results from the hegemony of medical power rather than from a well-considered measure of health justice. A raped woman who seeks a legal abortion and is confronted by medical teams with conscientious objectors suffers discrimination, beyond the unjust denial of the care she deserves. Thus, if it is possible to acknowledge conscientious objection through an institutional arrangement of healthcare teams, it is also fair to state that health institutions have the duty to guarantee care, without women having to be vexed by individual claims to deny them treatment.

The truth is that conscientious objection does not extend to all individuals as an absolute personal right. The technical norms that regulate legal abortion in Brazil are reserved for individuals directly involved in abortion procedures, that is, physicians [4]. On the one hand, if this moral reserve is a relief for women and their health needs, on the other it reflects what is protected by conscientious objection as a medical device – hierarchies rather than beliefs. Medical hegemony is safeguarded when one allows that

physicians' sentiments are untouchable. But the abortion taboo as a religious issue is also reaffirmed when conscientious objection becomes a medical right. After all, secularity becomes an adjective for public policies rather than a noun to legitimize political practices for justice in health.

1. Diniz D, Brum E. Uma história Severina [Internet]. Brasília: ImagensLivres; 2005 (accessed on 01/Aug/2013). Video: 23'. http://www.youtube.com/watch?v=65Ab38kWFhE.
2. Oliveira RM, Silva EQ. Interview with Debora Diniz about the film *The House of the Dead*. Vibrant: Virtual Brazilian Anthropology 2012; 9:535-50.
3. Savulescu J. Conscientious objection in medicine. BMJ 2006; 332:294-7.
4. Diniz D. Objeção de consciência e aborto: direitos e deveres dos médicos na saúde pública. Rev Saúde Pública 2011; 45:981-5.

Received on 02/Aug/2013
Approved on 06/Aug/2013