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ARTICLE

A Balance of Rights: The Italian Way to the Abortion Controversy

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Abstract

The U.S. Supreme Court's *Dobbs* ruling triggered a global debate about access to abortion and the legislative models governing it. In the United States, there was a sudden reversal of federal guidance about pregnancy termination that is unprecedented in Western and high-income countries. The strong polarization on the issue of abortion and the difficulty of finding a point of compromise lead one to consider the experiences of countries that have had different paths. Italy stands as a candidate for being a partially alternative model because it allows abortion up to 12 weeks, but without considering it a subjective right. The legislation in place since 1978 aims to balance the interests of the fetus and those of the woman. An issue often raised concerning Italian law is that of conscientious objection granted to doctors. Many gynecologists declare themselves objectors, and this makes access to abortion more difficult in some regions of Italy. After discussing this issue and envisaging different ways to deal with it, the article concludes by highlighting new dilemmas about a possible divorce between the law and medical ethics in different directions and offers some avenues to begin setting up a response.

Keywords: *Roe*; *Dobbs*; conscientious objection; Italian Act 194; medical ethics

Introduction: The "Right to Abortion" and a Cultural Divide

The *Dobbs v. Jackson Women's Health Organization* ruling (19-1392, 597 U.S.) handed down by the U.S. Supreme Court on June 24, 2022, marked a watershed in U.S. abortion jurisprudence and will most likely have significant political, social, and medical ethics consequences on a global scale. This is signaled by the immediate institutional reactions that the ruling has provoked. Indeed, it is a radical change of direction about the permissibility of abortion, which places the United States in a very different position from most Western and high-income countries. It was the 1973 *Roe v. Wade* (410 U.S. 113) ruling, now overturned, that had given a strong impetus to many national legislatures in Europe and elsewhere toward the legalization of the termination of pregnancy.

"The *Roe v. Wade* decision recognized that women under the constitutional provision of privacy had a right to make their own personal medical decisions including the right to have an abortion."[1] With the 1973 ruling, the Supreme Court legalized elective abortions during the first trimester of pregnancy. The Court permitted states to regulate, but not ban, abortions during the second trimester, except in those cases where a woman's health was at risk. In the third trimester, the states could give greater weight to the fetus and ban abortion, except when there was a serious threat to the life or health of the woman. The *Planned Parenthood v. Casey* decision in 1992 (505, 833 U.S.) used the imposition of an undue burden standard when evaluating state-imposed restrictions on that right, and the trimester determination was replaced by the test of the viability of the fetus.

The perspective adopted by the Supreme Court in *Roe v. Wade* was not to consider fetuses Constitutional persons but to value and protect the personhood of women at all stages of pregnancy.

In *Planned Parenthood v. Casey*, "the Court emphasized that the Fourteenth Amendment allows the government to advance interests in potential life but forbids it from doing so by exercising state power to control the lives and liberty of women who are pregnant (…) Casey's central teaching was that fetal protection cannot be advanced in a way that deprives the people who become pregnant of their Constitutional rights."[2]

The foundation of the earlier *Dobbs's* case rulings was privacy understood as "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child" (*Eisenstadt v. Baird*, No. 405 U.S. 438, 1972, at 488). But this involves the woman's personal liberty, which is specially protected and prevents the state from interfering with her most personal choices.

Dobbs v. Jackson Women's Health Organization stated that the Constitution of the United States does not confer a right to abortion, leaving it up to individual states the full power to regulate any aspect of abortion not preempted by federal law. A majority of justices agreed that abortion is not a constitutional right as the Constitution does not mention it, and its substantive right was not "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty," based on the criterion from *Washington v. Glucksberg* (521 U.S. 702, 1997).

Previously, it was assumed that state laws designed to restrict abortion before the fetus was viable placed an undue burden on women and their liberty to terminate the pregnancy. The limitations were deemed unconstitutional under the Due Process Clause referred to in the Fourteenth Amendment. However, the right to abortion could not be said to be absolute even after the Casey ruling. There were two limitations. The first was related to the government's interest in delivering the baby (hence the viability clause), and linked to this, the possibility that medical advances would cause the chance of survival of severely premature babies to increase.

"*Roe* recognized a state interest in potential life (the fetus), but never one that was greater than the health of the woman who carried it. Put another way, *Roe* stated that pregnant women were people who always deserved full Constitutional rights; rights that did not diminish because of pregnancy or the state's interest in potential life. Indeed, in reaffirming *Roe* in *Planned Parenthood v. Casey*, the Court emphasized that the Fourteenth Amendment allows the government to advance interests in potential life but forbids it from doing so by exercising state power to control the lives and liberty of women who are pregnant."[3]

The overturning of *Roe* did not make abortion illegal nationwide, but American society is characterized by high polarization and intense conflict. This is a situation that is also typical in other countries where there is struggle over the "right to abortion." This right is denied or guaranteed to varying degrees in different countries around the world, where it is often the subject of bitter social and political confrontation.[4] Therefore, it may be useful to consider other approaches to the issue that do not place a "right to abortion" at the center of legislation. One such example is Italy, where abortion has been legal since 1978.

Italian society was highly polarized in the 1970s. It is well known that the Catholic Church, with the presence of the Pope, had a strong influence at the time and directed the policies of the majority party, the Christian Democrats as well. Even the Communist Party, in opposition in Parliament, was lukewarm at first on the legalization of abortion. In contrast, a large secular and feminist movement with the small Radical Party led the pro-choice front. In Parliament, Act May 22, 1978, no. 194 was passed with only opposition from Christian Democrats and far-right forces. Catholic militants supported by the Church later promoted a repeal referendum, whereas the Radical Party proposed another referendum to make the law more permissive. Both demands were rejected by the popular vote in 1981, effectively giving more force to the law that expressed a compromise between strongly opposing demands and sensitivities. From then on, albeit with high tensions, as will be described below, the moderate form of legalization of abortion gradually won wide acceptance. Today, no political party, not even the new majority elected in 2022, heir to the right-wing parties that had opposed the passage of Act 194, declares its intention to change it, nor does the Catholic Church, still strongly opposed to abortion, seek to promote initiatives against the law.

The Italian Law on Abortion: A Different Approach

The strategy of Act 194 was very different from the approach taken by *Roe*. While *Roe* established abortion as a sort of Constitutional right, Italian law conceives of abortion as an extreme measure that is decriminalized under certain conditions but should be avoided whenever possible. Act 194 passed in May 1978 centers on the social protection of responsible motherhood and rejects conceiving abortion as a means of birth control.

Article 1 says that the State must develop social and healthcare services to promote birth control to avoid abortion being used for this goal. The main purpose of the law is the prevention of abortion, that is, to ensure that unwanted pregnancies are minimized, rather than to grant women the right to terminate their pregnancy; this purpose is entrusted to the social services, so that, unlike the United States, abortion is not a *private* choice but an individual choice with significant *public* and *social* dimensions. This is indicated by the title of the act that sets the "social protection of motherhood" as its goal, *before* mentioning the voluntary termination of pregnancy.

This does not mean that women are not allowed to make a choice with reference to their pregnancy; nonetheless, there are conditions set by the law, even during the first trimester. Up to the 90th day of pregnancy, a woman can obtain an abortion within the context of the national health service provided that the continuation of the pregnancy would involve a *serious* risk to her physical or psychic health. She must have recourse to her family doctor, or a public healthcare institution, and have a conversation with a physician. Beyond visiting with her, the physician must explore solutions that could alter her decision to terminate her pregnancy.

The law attributes the services of family counseling the task to inform women on the social, healthcare, and caring services available in the area, as well as to initiate special interventions to tackle difficulties either during pregnancy or after birth. The avowed goal of this procedure is to offer social solutions to situations in which women may be tempted to terminate their pregnancy because of working, economic, or other social difficulties. After this conversation with the physician, the woman must pause for 7 days—unless conditions of urgency exist—before she can go to a public facility, or one in agreement with the NHS, and obtain the intervention. Abortion in private facilities, except where an agreement with the NHS is ongoing, is strictly forbidden; whoever performs an abortion outside authorized facilities can be condemned up to 3 years of imprisonment, and the woman is liable to pay a fine. As a matter of fact, the overwhelming majority of abortions are performed in public hospitals.

In short, the legal approach does not build on the recognition of a woman's right to the State's noninterference with her decisions concerning what happens to her body, rather on the recognition that there are two different interests in conflict and that the State must arbitrate between the two. The reason why abortion can be accepted, therefore, is not that the woman has a right to be left alone, but that she has a right to terminate a pregnancy that may present risks for her health: it is not a right to privacy that is here at stake, rather a right to health. Article 32 of the Italian Constitution declares that "The Republic protects health as a fundamental right of individuals, as well as an interest of the community." The reason for accepting abortion is not the protection of women's self-determination, but the State's interest in protecting the woman's health in the context of reproduction.

The fact that healthcare is also an interest of the community helps us understand why in Italy abortion is not conceived as a private choice but as a social problem. The interest in protecting health, and specifically in avoiding the threats of backstreet abortion, justifies a policy centered on the social protection of responsible parenthood, that is, on the social interest in ensuring that people conceive offspring only when they want to become parents. Moreover, the State's legitimate interest in protecting unborn human life also contributed to excluding the decision to terminate pregnancy being considered entirely private. Such an interest is apparent from Article 1 of the Law, which says that "The law protects human life from its inception." This is somewhat ambiguous wording because it does not make clear when human life begins; nonetheless, it can reasonably be interpreted in the sense that the law offers some protection to the human fetus from the very start, even if it does not ascribe to it a right to life. In any case, such a protection does not extend to the use of the methods of emergency contraception. The Italian law treats both the "morning after pills," such as those containing levonorgestrel (e.g., Norlevo),

and the "5 days after" ones, such as those containing ulipristal acetate (e.g., ellaOne), as contraceptive methods, even if they may have antinidatory effects. The former kind of drug is subject to obligatory medical prescription only for minors, whereas the latter are freely purchasable in pharmacies also by minors.

The Law, therefore, acknowledges the existence of two legitimate interests—the fetus's interest to have a chance to develop into a fully human individual and the woman's interest to discontinue an unwanted pregnancy—and tries to strike a balance between them, granting some prominence to the second during the first trimester and providing stronger protection to the first after that time. In fact, after the 90th day of pregnancy, the conditions for legitimate abortion are stricter: A woman can obtain an abortion only if the continuation of the pregnancy would involve a *severe* risk to her life or if there is evidence of significant fetal malformations that cause a *severe* risk for the woman's physical or psychic health. This last provision is removed at viability, that is when the fetus can survive outside the mother's womb; at this time, abortion can be performed only to save the woman's life, and the physician must use any means to protect the fetus's life. Here, the therapeutic goal is of paramount importance, and there is no space at all for a woman's decision based on her desires. Infringement of these provisions is punishable with imprisonment up to 4 years, and the woman can be imprisoned as well up to 6 months.

The Italian law does provide a Constitutional reason for accepting abortion; however, unlike *Roe*, it does not find it in the notion of liberty—even though Article 13 of the Constitution defines personal liberty as "inviolable"—rather in the right to healthcare. Moreover, it provides comparatively stronger protection to the fetus' interest to have a chance for life. Finally, it also grants physicians and other healthcare practitioners the opportunity to raise their conscientious objection (CO); in fact, Article 9 of the Act states that they can refrain from participating in the procedures specifically aimed at the termination of pregnancy (not from taking care of the patient before and after the intervention), provided that they declare their objection to the healthcare provincial authority and, for hospital professionals, also to the chief medical officer. Healthcare professionals have a duty to take part in the abortion procedure when this is indispensable for saving the woman's life from impending risk; apart from these situations, an objector's CO is automatically canceled if he or she takes part in abortive procedures. Abortive procedures are not limited to surgical interventions, but also include pharmacological prescriptions. Since 2010, Italy has approved pharmacological abortion, consisting of the administration of mifepristone and prostaglandins at a distance of 48 hours; the procedure is presently available up to the 63rd day of pregnancy in clinics that are linked to hospitals and are authorized by regional authorities. In 2020, pharmacological procedures accounted for 35% of the overall number of abortions.

The Italian law, therefore, is a paradigmatic example of the attempt to accommodate all the interests involved in the abortion situation and to give each due weight without granting any unconditional priority. When seen from one or the other extreme perspectives, such an attempt may be criticized as a failed compromise[5,6]; however, from a more impartial and unprejudiced viewpoint, this attempt appears reasonable. Act 194/78 adopted a moderate perspective that escapes both extremes: on the one hand, the unconditional prominence given to the woman's interest in terminating her pregnancy by policies such as the ruling in *Roe*; on the other hand, the unconditional protection of the fetus's interest, and the substantial disregard for the mother's one, provided by laws such as the 1925 Act of Texas that has been revived after the withdrawal of *Roe.* The moderate perspective adopted by the Italian law seems justified in light of its conceiving the abortion decision within a social framework, and of its pursuit of the goal to prevent abortions as much as possible.

Almost 45 years after its enactment, it can be said that Act 194/78 has substantially achieved its goals, in particular the goal of reducing the number of legal abortions. Even if critics of how the law was applied insist (with good reason) on the limits of the preventive measures that the health and social services have provided in these decades to make the woman's decision not to choose an abortion more viable, there can be no denying that the abortion figures in the country have significantly decreased. Based on the annual relations that the Ministry of Health must present to the Parliament,[7] it should be noted that the total number of abortions in Italy has been constantly decreasing since 1983. The highest number of abortions (234,801) was registered in 1982, 4 years after the enactment of Act 194; according to the latest available

data, in 2020, there have been 66,413 abortions, with an overall reduction of 71.7%. The abortion rate—meaning the number of abortions every 1,000 women between 15 and 49 years—is now at 5.4, with a reduction of 68.5% as compared with 1982.

The progressive reduction of abortions—mostly to be ascribed to the spread of contraceptives—is still ongoing, as witnessed by the fact that in 2020 there has been a 9.3% reduction in total numbers, and a 6.7% reduction in the abortion rate, compared with 2019. It is also noteworthy that almost one-third of the total number of abortions (28.5%) regards foreign women, a population whose abortion rate is much higher than that of Italian women; however, it can also be observed that in the last year, the total number of abortions in this subpopulation has decreased much more than for Italian women (−11.1% vs. −8.5%). The population with the highest abortion rate is that of women aged between 30 and 34, whereas young girls have a particularly low abortion rate (for women under 20, it was 3.0 in 2020, with a reduction of 18.3% compared with 2019 and 62.1% compared with 1982; and the datum decreases to 1.9 for minors); this datum is the lowest in Europe and almost half of the U.S. rate (where it was 5.8 in 2019). Overall, the abortion rate in Italy is lower than in any other European country and is less than half the U.S. rate (where it was 11.4 in 2019). Critics of the Italian law have suggested that this lower rate may be accounted for by the high level of backstreet abortions per year that still exist, and by the high number of women who go abroad to obtain an abortion. This hypothesis, however, is supported by anecdotical evidence and speculations since there are no reliable statistics on this topic. If having an abortion is in any case a dramatic event in a woman's life, these data cannot but be judged favorably.[8]

In short, Italian law adopts a significantly different approach from the U.S. one. Whereas in the United States, according to *Roe*, the decision whether to continue her pregnancy during the first trimester was entirely within the liberty rights of the woman, who could not be limited in any way in fulfilling her desires, in Italy, abortion is not something entirely belonging in the domain of women's self-determination. Rather, it is a procedure that is not punishable under certain rather strict conditions. Therefore, it can be said that properly speaking there is no right to abortion in Italy.

However, the debate on the subjective right to abortion has been very lively in Italy. In Italian law, a subjective right is a recognition by the legal system (i.e., objective right) of a claim, which implies an obligation of others not to do or to do. It involves the power to act to defend the recognized and possibly threatened interest. Rights and obligations are thus correlative.

Constitutional jurisprudence since the 1970s has recognized the "constitutional basis" of the right to life of the conceived (ruling no. 27/1975). Moreover, a ruling following the passage of the law declared inadmissible a referendum request aimed at eliminating some limits placed on abortion by Act 194, relying on the argument that "the right to life, understood in its broadest extension," is to be included "among those rights that occupy a position in the legal system that is, so to speak, privileged, since they belong 'to the essence of the supreme values on which the Italian Constitution is founded'" (ruling no. 35/1997).

The Italian approach pays much more attention to the social aspect of abortion and aims to provide recognition of the interests of all the parties involved. Moreover, although the law has traditionally been criticized by feminist and liberal thinkers as too restrictive,[9,10] it can be said that it represents a reasonable compromise. Not by chance, it still seems to enjoy a large consensus in the population and has never been the object of serious attempts of modification.

Problems with the Italian Approach: Conscientious Objection and the Balancing of Different Claims

The consensus is not unanimous, however, because there is one point that has been the object of continuous and severe criticism and that leads critics to charge the Italian law with failure to take seriously the women's right to abortion.[11] This is the high percentage of conscientious objectors, a situation that, at least in some regions, seems to hinder the very possibility to obtain abortion services.

As mentioned above, Article 9 allows healthcare professionals to raise their CO simply by notifying the provincial medical authorities and, in the case of hospital professionals, the chief medical officer. Italian doctors have shown a strong disposition to avail themselves of such a conscience clause. The

present situation is that, in 2020, 64.6% of gynecologists, 44.6% of anesthesiologists, and 36.2% of nonmedical personnel have raised their CO. Concerning the gynecologists, the datum is slightly decreased, compared with 2019, when it had reached the level of 67.0%.

The incidence of CO determines a situation in which only 63.8% of healthcare facilities with a gynecology ward offer abortion services; there are substantial differences between different areas of the country, but at least in two cases (the autonomous province of Bolzano and the region Campania), the percentage of public facilities offering abortion services is less than 30%. This also causes a significant workload on those physicians who are non-objectors: the mean number of abortions that non-objectors must perform at a national level is 1 a week, but in three regions, there are facilities with working loads for non-objectors that reach, respectively, 9.7 (Abruzzo), 9.9 (Campania), and 16.1 (Sicily). According to critics, these data show that the Law has had a discriminatory impact on women living in the South and rural areas.[12] The situation is somehow worsened by the fact that Italian law excludes all physicians who are not gynecologists from taking part in abortion. Although it accepts "pharmacological abortions," it reserves the prescription of the relative drugs to gynecologists, forbidding primary care physicians to do so. This provision contributes to enhancing the impact of CO.

It cannot be excluded that these high rates of CO are also the effect of the physicians' desire not to dedicate a considerable amount of their time to terminating pregnancies. In any case, there may also be another reason, beyond the influence of sincere reasons of conscience, that helps explain these high percentages: it is the fact that, in some local situations, being a conscientious objector may promote your career. In fact, since appointments in public hospitals are under the control of regional governments, when there is a political or ideological commitment, on the part of the ruling majority, to hinder access to abortion, declaring one's CO may help obtain senior positions.

Be that as it may, it seems difficult to deny that the present situation is causing difficulties in the pursuit of the law's goals. In truth, an attempt was taken to demonstrate the lack of correlation between the number of conscientious objectors and waiting times for obtaining an abortion.[13] It was shown that, when two nonconsecutive years are compared, no stable correlation can be observed between the proportion of objectors and the proportion of women who obtained abortion either promptly or later; that is, in some regions where the percentage of objectors had increased, waiting time had decreased, and in some in which the proportion of objectors had decreased, waiting time had increased. This may suggest that the difficulties in the implementation of the law are due to the different regional organizations of abortion services, and to the general accessibility and efficiency of health services.

However, such conclusions were criticized as arbitrary, since the mere random selection of two nonconsecutive years cannot presuppose that stable trends are active; if two different nonconsecutive years are selected, different results obtained.[14] In short, the method used is unable to demonstrate the absence—as well as the presence—of a correlation between the two parameters under consideration; on the other hand, other studies, considering longer periods, have suggested that the proportion of objectors in one region is inversely correlated to the proportion of women who promptly obtain an abortion.[15] Moreover, these studies have also shown that the prevalence of CO is one factor—along with avoidance of social stigma, the geographical proximity of hospitals outside of the home region, general mobility for healthcare services, and interregional migration—that leads many women to seek an abortion outside of their home region.

Critics of this situation conclude that an imbalance in the protection of competing claims has come about. Whereas the practitioners' right not to take part in abortion procedures is given full protection, the women's right to receive an abortion is severely limited, at least in certain areas of the country.[16,17] There are local situations in which women must drive for several miles to find a healthcare facility that offers abortion services or must travel to another region to abort; in other situations, they have to wait a considerable amount of time to obtain the intervention because of the scarcity of the available personnel. This situation calls for redress. There are two possibilities: either to abrogate Article 9 of the law or to partly modify it, to make the option of CO less easy and more demanding.

The first option is defended by those who accept the so-called "incompatibility thesis," according to which there is an incompatibility between CO and the modern practice of medicine:[18,19,20] the latter being based on the patient's right to receive any treatment that is scientifically safe and legally approved.

The physician's moral beliefs should have no bearing on whether a treatment is provided or not. It is often noted that the provisions of Article 9 were reasonable in 1978 when the law suddenly removed an age-old ban that had always characterized the medical profession; unwilling physicians had a legitimate claim not to be involved in a practice they had always considered contrary to their professional commitment. However, the option of CO is no longer reasonable now, when everyone knows that the termination of pregnancy is part of the medical profession, and all the active members of the profession have started to practice when the law was already in force; if anyone does not want to terminate pregnancies, he or she should not become a gynecologist, or an anesthesiologist.[21]

Several objections have been raised against the incompatibility thesis, and we believe that there is room for defending the reasonableness of a limited recourse to CO in contemporary medicine.[22,23] In the context of the present paper, we only stress the fact that the incompatibility thesis seems at odds with the Italian Law's avowed effort to accommodate all the conflicting interests in the abortion situation; the mere abrogation of Article 9 of the Act would simply reject the claims of objecting physicians, coercing them to choose a different specialization. The option to modify the article to pursue a better composition of conflicting interests seems more in line with the "spirit" of Act 194/78.

One possibility that has been explored is that of asking prospective objectors to provide more detailed information on the grounds of their objection; the obligation to provide specific declarations arguing for one's moral commitment to defend human life may deter some "inauthentic" objectors from claiming CO. Critics of this strategy note, however, that it is not likely to provide significant relief to the present situation. One more promising possibility is to ask conscientious objectors to perform some extra duty in compensation for their claim to CO; it may be hypothesized that conscientious objectors be asked to contribute some more holiday working hours or some more night shifts.[24,25]

The fact that being a conscientious objector presents some extra "cost" may be more effective in deterring "inauthentic" objectors from raising their claims. On the other hand, this strategy may be charged with embodying unequal treatment. In the attempt to drive out inauthentic objectors, it seems to overburden the authentic ones with undeserved extra work. Another option is to act on the mobility of personnel between different hospitals in the same Region; Article 9 already allows the Regions to move objectors and non-objectors from one hospital to another to grant a fair number of both in every regional facility. A wider recourse to this strategy may contribute to the solution of the problem; however, it would probably achieve little in regions where the percentage of objecting doctors is particularly high.

Another strategy would be to make separate contests for non-objectors, so that healthcare facilities may hire the personnel they need to provide abortion services. This option requires some change in Article 9 because at present CO may be invoked at any time; in the hypothesis of reserved contests, however, someone applying as a non-objector should not be allowed to invoke CO once he or she has obtained the job; otherwise, this solution becomes useless. This solution would probably be effective but may be accused of establishing a sort of "ideological" condition for applying to an open competitive exam, which may be legally controversial.

A final proposal is to use a quota system for specialist medical trainees to regulate the number of COs from the very start.[26] If a sufficient proportion of non-conscientious objectors is guaranteed among those who annually access specialist training in the relevant disciplines, then within a certain time, the shortage of physicians willing to provide abortions will be reliably prevented. The maximum quota of objectors should be lower than present rates, to avoid the risk of negatively impacting the provision of the service, and to allow for changes in belief that may reasonably occur during one's career. This option may still be accused of reducing the freedom of conscientious objectors to enter their preferred specialization but can plausibly be offered as a reasonable compromise.

In sum, the attempt to promote better consistency between the women's right to obtain an abortion and the practitioners' right to CO seems inherently reasonable and consistent with the moderate approach taken by the Italian Act 194/78. The strategies to foster the coexistence of the two rights are partly problematic, but it seems that reasonable accommodation is likely to prove possible. Some legislative intervention to better define the conditions of CO may be required; the best solution remains to provide extra efforts to implement the preventive aspects of the law. A reduction in abortion rates is

the first and most important purpose of Italian law, and the best strategy to solve the problems posed by CO as well.

Conclusions: Medical Profession and the Law

As seen in the previous sections, the Italian approach to the issue of abortion has not been to affirm a subjective right to terminate pregnancy but to balance different and sometimes incompatible interests between women and the fetus. Thus, access to abortion up to the 12th week of pregnancy is guaranteed within a regulated process that places some formal limitations, although often easily overcome in practice. This legislative framework seems to have created a stable balance given the country's values and cultural orientations and social sensitivities. The high rate of CO by physicians creates some tension at a local level, but overall, it does not seem to significantly undermine respect for women's interests within the existing law.

On the other hand, "an acrimonious battle between two competing ideologies remains at the crux of U.S. abortion politics."[27] Against this backdrop, it is worth reflecting on the changes in political majorities and the consequences these have on the law—in the United States through the composition of the Supreme Court, in Italy through the change of laws operated by Parliament—and the role of the medical profession, which has the key role in performing an abortion.

As noted in the outcome of the 2022 Midterm elections, the overturning of the *Roe* ruling led many voters to choose candidates who are in favor of abortion rights signaling that the Supreme Court's decision in the *Dobbs* case does not have the support of a large majority of the population. In Italy, a center-right coalition won the elections in 2022, and the government, which claims to be closer to the American Republican Party than to the Democratic Party, has stated that it is not willing to change Act 194/78, which legalizes abortion, but only to better enforce it. On the one hand, this may mean trying to close loopholes that make abortion easier to obtain than the new majority in Parliament believes is justified. On the other hand, it may mean an increase in the provision of psychological, economic, and social support to women who want an abortion, in the original spirit of the act. Whether this constitutes undue interference in women's free choice is an open question between the pro-choice movement and the antiabortion movement.

In the United States, after the *Dobbs* ruling, the medical profession expressed strong concerns about the health and safety of pregnant patients in states where abortion has been banned. Furthermore, discussions have begun about "professional obligations after *Dobbs*."[28] Already people are wondering whether refusing to comply with the new regulations is an ethical choice or if civil disobedience is the wrong answer to them. The CO would thus have two possible directions, so to speak.

In Italy, the CO of physicians is regulated by law and is exercised in the prescribed forms. The doctor refrains from performing an abortion if it goes against their personal and professional ethics, even though their choice may in some cases harm the woman's interest in obtaining an abortion, which the state is still obliged to provide. In the United States, would a physician who considered it both their professional duty and descended from their ethics to grant an abortion to a woman under certain circumstances qualify such a choice as CO to the law or civil disobedience?

Civil disobedience[29] is a public, nonviolent, and conscientious breach of law undertaken with the aim of bringing about a change in laws or government policies. "On this account, people who engage in civil disobedience operate at the boundary of fidelity to law, have general respect for their regime, and are willing to accept the legal consequences of their actions, as evidence of their fidelity to the rule of law."[30]

It seems plausible to think that there will be three groups of physicians in the United States regarding deontological orientation. The first is those who are opposed to the practice of abortion and who will be satisfied with the consequences of the *Dobbs* ruling. The second is the group of those who think the decision is wrong and think that abortion is not against medical ethics but respect the current laws. The third group consists of those who think they must transgress the law to obey their conscience and professional ethics by guaranteeing women's reproductive rights, even at the cost of criminal penalties.

This seems to call for a new and additional bioethical reflection, given that the American situation, where largely permissive legislation on abortion has been suddenly overturned based on interpretations of the Constitution, is quite unprecedented. Before the legalization or decriminalization of abortion, there was an alignment between state law and ethical codes of the medical profession. Over the past 60 years, sensitivities have changed at the urging of different actors, and now the scenario in the United States challenges the medical profession to find a point of confluence or compromise in the face of new norms.

Before the legalization of abortion, medical ethics codes prohibited physicians from performing voluntary abortions when the pregnant woman's life was not in severe danger. After the legalization of the termination of pregnancy, medical ethics codes were adjusted in short order. It can be assumed that this was the result of a change in the evaluation of abortion that went hand in hand with the demands expressed by society and then accepted by legislators. However, when there is a sudden change at the political or judicial level, how, if at all, should medical ethics codes change? Can medical ethics be sharply divided on an issue as important as abortion? In Italy, the solution has been CO for healthcare professionals who find abortion morally unacceptable, with the consequent issues discussed above.

One can then ask what the dialectic between state law and professional ethics should be. In a mature democracy, can the two be sharply at odds? Ideally, medical ethics laws and codes should be fine-tuned based on a reflective equilibrium in which all relevant actors involved in decisions about abortion can have a voice. In this sense, the medical profession can also give inputs to the legislature based on its specific skills and sensitivities. The American case, where physicians could choose to raise their CO in a contrary direction to that allowed in Italy, highlights the difficulty of reconciling different positions and the need for further moral elaboration both at the general level and at the level of medical ethics.

In fact, concerning Italian legislation and CO, the following criticism could be raised. If abortion in Italy is not about a right to privacy but about a certain social concern and social response, then when one allows physicians to easily resort to CO, one is granting them a sort of privacy right which is denied to women. But, again, the answer might be that the right to CO is not based on privacy as understood in the American legal system. It is based on freedom of conscience and the values of (a part of) the medical profession. Italian legislators have deemed them to override other considerations, that is, not directly commensurate with the right of women to have an abortion when requested.[31]

So, the course taken in Italy, although far from perfect, provides some insights that can contribute to the overall debate on the divisive issue of abortion in contemporary pluralistic societies.[32]

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31. The authors thank a reviewer for pressing them on this point.
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