Let's talk about conscientious objection

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Some years ago I had a registrar who was and remains a devout Buddhist. He was shocked when he attended my gynaecology operating list: "Abortion is a sin!" he exclaimed. Sometime later he revised his thoughts: "Abortion is a sin, but I don't see why you should have all the sin. I will share this sin with you". He had, in his own way, changed his mind.

Conscientious objection (CO) remains an important issue in clinical practice, particularly in relation to the provision of abortion. In England, Scotland and Wales the Abortion Act 1967[1] states that: "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection". The Royal College of Obstetricians and Gynaecologists (RCOG) has issued guidance for trainees[2] for further clarification, which emphasises that doctors may opt out of witnessing and performing abortion, but that they must not withhold clinical advice to patients or impose their views on others. They should make the preparatory steps to arrange an abortion where the request meets the legal requirements, and these might include referral to another doctor. Such rights need to be balanced by the requirements of the General Medical Council (GMC), as stated in its publication *Duties of a Doctor*,[3] and do not cover other areas of possible CO, such as contraception.

The Faculty of Sexual & Reproductive Healthcare (FSRH) has published guidelines[4] for healthcare professionals (HCPs) on CO, encouraging openness about personal belief to ensure service provision. These guidelines recommend that HCPs review their personal beliefs and the impact they may have on patient care at their work-based annual appraisal or equivalent. They also make the point that religious belief needs to be respected as a 'protected characteristic' under the Equality Act 2010. These recommendations were discussed in an editorial in this Journal,[5] emphasising the point that a patient should never be disadvantaged by the views of any HCP they see.

CO could impact on abortion services if doctors decline to take part in abortion. At a global level, a 2018 report from the International Women's Health Coalition[6] highlights this concern and identifies the need to collect better data on the prevalence of CO worldwide. There is no such registration system in the UK at present. The report also highlights that the expression 'conscientious objection' arose in a military setting for those under conscription, rather than those voluntarily employed within the health sector, and that it is all too easily used as a way to refuse provision of services. Information on the prevalence of CO may be further complicated by 'partial objectors' who may offer abortion, say, for fatal congenital abnormality, but not for other reasons. Is it reasonable to invoke CO for some cases, but not for others?

The question is complex as interpretation of the law on abortion in England, Scotland and Wales is open to bias on the part of the medical practitioners involved. Most abortions are carried out where two doctors state that they believe, in good faith, that continuation of a pregnancy would involve greater mental or physical harm than if the pregnancy were terminated. This is widely interpreted as termination at the request of the woman, but if any recommendation on this matter is offered by the doctor this must involve some form of judgement on their part. Clinical judgement in itself is an essential part of practice, but 'in good faith' could be swayed by the doctor's personal opinions.

Further bias may be introduced by others, such as midwives. The Royal College of Midwives issued a Position Statement[7] in May 2016 supporting

women's choice, but also affirming its support for midwives with CO to abortion. In an appeal case in Scotland in 2014, a judgement was made to uphold the position of two Roman Catholic midwifery managers, whose CO extended to any involvement in the process of treatment, including the delegation, supervision and support of midwives. That decision was overturned by the United Kingdom Supreme Court,[8] the debate focusing around how far individuals actually participate in abortion treatment.

There is a strong ethical case against CO, as declining involvement in abortion has negative repercussions. These include the risks of delaying treatment, embarrassing or stigmatising the patient, and giving additional work to colleagues. In countries where abortion is not easily available, unsafe abortion still carries a high complication rate.[9] Passing the case on to a colleague does not make the clinical problem go away. For these reasons it has been argued there should be no place for CO in clinical practice.[10]

What, if anything, should be done? CO is not recognised in Sweden, Finland and Iceland. Fiala el al. suggest that CO should be re-named 'dishonourable disobedience', and that a system where it is not allowed is both workable and beneficial.[11] I personally find it hard to imagine practising in circumstances where CO is never an option: would this deny the autonomy of doctors who are, after all, responsible for their actions? Requiring a doctor to do something they do not agree with, even if there is a strong ethical case for it, would not produce good medicine: the quality of consultation would suffer and the doctor may move into other areas of practice, with the risk of depleting certain hard-pressed specialties. The GMC requires a doctor to respect the cultural values of others. Does the same respect also apply to medical practitioners? If not, then doctors are being set apart from their patients. It is in everyone's interests for practitioners to be treated as people, too. Freedom of conscience should be allowed even if you disagree with its consequences.

How then can these different positions be reconciled? Withdrawal from service provision could be formalised with a registration system, as in Italy, where it has been reported that 70% of obstetrician-gynaecologists have submitted a form to the Ministry of Health as objectors to abortion.[12] That way data are collected for planning of service provision, and CO would be recognised as the serious matter that it is. Publication of such data also creates debate, and potential protest by women's health groups such as Non Una di Meno in Italy.[13]

Discussion of CO is difficult where strong, often faith-based opinion collides with evidence-based medicine, but I believe this is necessary, beginning at undergraduate level. The sensitivities of this contested domain should be acknowledged, but their implications also thought through in a non-judgemental way. Students and doctors need to consider their special position of power over people in vulnerable situations, who may have nowhere else to turn. Should doctors be allowed to impose their personal values when they have chosen a profession whose commitment is to serve the public? To what extent is the autonomy of the doctor essential? CO is not always based on religious faith, and people have the capacity to change, which is the very nature of learning. Personal faith or belief need not be inconsistent with logical reasoning. Fresh understanding comes from hard data but also from story-telling, debate, case discussion, and talking with women who present with unwanted pregnancies. The consequences of denying women easy access to abortion services need to be understood and reflected on. If CO is to be valued within our practice then trainees should be encouraged to consider their own moral position. It is too easy to accept CO as an end to debate, when it should be a beginning.

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REFERENCES

1 legislation.gov.uk. The Abortion Act 1967. Available: http://www.legislation.gov.uk/ukpga/1967/87/contents
2 RCOG. Advice for trainees on termination of pregnancy. Available: https://www.rcog.org.uk/en/careers-training/resources-support-for-trainees/advice-and-support-for-trainees/advice-for-trainees-on-termination-of-pregnancy/
3 General Medical Council. Duties of a doctor. Available: https://www.gmc-uk.org/-/media/documents/good-medical-practice-english-1215_pdf-51527435.pdf
4 FSRH. Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception. Available: https://www.fsrh.org/documents/guidance-for-those-undertaking-or-recertifying-fsrh/
5 Kasliwal A, Hatfield J. Conscientious objection in sexual and reproductive health - a guideline that respects diverse views but emphasises patients' rights. *BMJ Sex Reprod Health* 2018;44:5–6.
6 International Women's Health Coalition. Unconscionable: when providers deny abortion care. IWHC, 2018. Available: https://iwhc.org/resources/unconscionable-when-providers-deny-abortion-care/
7 Royal College of Midwives. Position statement abortion, 2016. Available: https://www.rcm.org.uk/media/2296/abortion-statement.pdf
8 Supremecourt.uk. Judgment. Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014. Available: https://www.supremecourt.uk/cases/docs/uksc-2013-0124-judgment.pdf

9 WHO. Preventing unsafe abortion, 2018. Available: https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion
10 Fiala C, Arthur JH. There is no defence for 'Conscientious objection' in reproductive health care. *Eur J Obstet Gynecol Reprod Biol* 2017;216:254–8.
11 Fiala C, Gemzell Danielsson K, Heikinheimo O, *et al*. Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care. *Eur J Contracept Reprod Health Care* 2016;21:201–6.
12 Italian Ministry of Health data, 2014. Available: http://www.salute.gov.it/portale/documentazione/p6_2_2_1.jsp?lingua=italiano&id=2428
13 Iacobini di Fazio M. Italian cities "turn back the clock" on women's reproductive rights. *Global Post* 2018.