Conscientious objection in sexual and reproductive health – a guideline that respects diverse views but emphasises patients' rights

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The Faculty of Sexual & Reproductive Healthcare (FSRH) is the principal professional body for doctors and nurses working in sexual and reproductive health (SRH) care in the UK. Its members include doctors, both general practitioners and specialists, and nurses working in primary care and specialist services.

Conscientious objection to aspects of professional practice is an issue that is particularly relevant to SRH practitioners, given their involvement with controversial aspects of healthcare such as contraception and abortion. In fact the dilemmas these issues can raise are relevant to all healthcare professionals wherever they are practising and under whatever legal framework. This article explains the process by which the FSRH recently reviewed its guidelines on conscientious objection, and presents the essential and universal ethical issues this process raised, as listed in the box.

In 1999, the FSRH published guidelines for potential trainees who express conscientious objection to aspects of care – recognising that even in its particular area of medicine there is a broad range of views among professionals towards abortion care and some forms of contraception. These guidelines set out the FSRH´s requirements of professionals who undertake its qualifications and recognised the legal right of healthcare professionals in the UK to opt out of aspects of abortion care. In 2014, this guidance was updated to include nurses, who had by then become eligible to undertake some FSRH qualifications.

While no significant amendments had been made to the guidance at the time, their content was challenged in an article by the Chief Executive of the Christian Medical Fellowship (CMF).[1] The article accused the FSRH of discriminating against Christian doctors by stating in its guidance that a prescribing healthcare professional must be able to prescribe *all* forms of contraception in order to be awarded the FSRH Diploma – a qualification for doctors and nurses carrying out routine contraception consultations. This campaign was also picked up by some individuals in the USA and by a handful of members of both houses of the British parliament.

Believing the CMF article to be inflammatory and largely inaccurate, we felt comfortable 'defending' our stance as it seemed entirely reasonable that as a training organisation we should expect a Diploma-qualified member to be willing to carry out full and effective contraception consultations and prescribe all forms of contraception. However this challenge did give us pause for thought, and as we began discussing the issue with our members, it became apparent that there is a wide spectrum of views in the sector – from overt 'conscientious objection' to delivering abortion care or fitting intrauterine devices (IUDs) as emergency contraception (EC), through to a belief in 'conscientious commitment' to delivering the care that women need regardless of personal beliefs. We therefore drew together a group of members, non-members and academics to offer a range of views to inform our position. This group met on four occasions to discuss what an appropriate stance should be for the FSRH, a membership and training body, and a charity, whose aim is to ensure high standards of care in SRH services.

Because conscientious objection to provision of abortion care is enshrined in UK national law,[2] as it is in many countries, abortion was not the main focus

Box Ethical issues raised during review of Faculty of Sexual & Reproductive Healthcare (FSRH) guideline on conscientious objection

- How can the rights of the healthcare professional be balanced with the rights of the patient?
- Should healthcare professionals have to be 'open' about their religious or ethical views to their employers, their patients, or their training bodies?
- What happens if their views change?
- Should professionals with conscientious objections be made aware of any consequences for the patient that may result from their stance?
- If professionals choose the specialty of sexual and reproductive health, should they be expected to deliver all forms of contraception and abortion care?
- Do professionals feel safe discussing this issue, and if not, what problems does this highlight in medical and nursing training and in daily practice?

of our discussions. The more controversial issue was whether a doctor or nurse would have to be willing to prescribe or fit an IUD as a form of EC if she or he had a personal belief that this was wrong. To begin with we argued back and forth over whether, as an independent training organisation working in the field of SRH, we could or should decide whether to insist on this as part of completing the requirements for our Diploma qualification, the DFSRH. We also recognised that beliefs can change over a clinician's lifetime. Through discussion, we came to understand that we could not cover all circumstances in which healthcare professionals provide care, and that the important thing for us as a professional body awarding and governing qualifications is that patient care is provided to the high standards that we support.

Finally we arrived at the key principle that a patient should never be put at any disadvantage as a result of the views of any healthcare professional they see. We have enshrined this principle in our 2017 guidance document,[3] as a principle of care which all trainees must meet, whether undertaking the Diploma or doing other 'general training' in SRH through the Faculty. So, for example, a doctor wanting to qualify for or re-certify the DFSRH could decide not to prescribe a particular form of EC, but would have to agree to be open about this to their service or employer, to enable arrangements to be made to ensure that there was no delay to the patient in being provided with that care. Furthermore, whatever arrangements are made by the clinician, they should not in any way suggest a judgement about the patient.

So the heart of the new guideline is that we welcome members with a range of views, and we will award the relevant Faculty qualifications to those who fulfil all training requirements and are willing to show that they will put patient care first, regardless of their personal beliefs.

Having started this debate about the impact of personal beliefs on the delivery of care and the awarding of qualifications at the FSRH, we hope to continue it. We have already benefited enormously from the discussion about these issues. We hope to receive feedback on the new guideline and we very much look forward to continuing this important conversation. Both patients and healthcare professionals can only benefit from environments in which practitioners can be open about their beliefs while putting patient care first.

Competing interests None declared.

Provenance and peer review Commissioned; internally peer reviewed.

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2 The Abortion Act 1967, Section 4. www.legislation.gov.uk/ukpga/1967/87/section/4 (accessed 27 Oct 2017).
3 Faculty of Sexual & Reproductive Healthcare (FSRH). Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception. 2017. https://www.fsrh.org/documents/guidance-for-those-undertaking-or-recertifying-fsrh/ (accessed 27 Oct 2017).

BMJ SEXUAL & REPRODUCTIVE HEALTH

Revised trainee guidelines permit full spectrum of 'conscientious objection'

But clinicians must put patients' sexual/reproductive health needs first whatever their beliefs

Trainee doctors and nurses can opt out of providing certain aspects of sexual and reproductive healthcare, but only if they can ensure that patients' needs are still being met, whatever their own personal beliefs, say new guidelines on 'conscientious objection' from the Faculty of Sexual and Reproductive Healthcare (FSRH).

Explaining the thinking behind the updated guidance in an editorial in *BMJ Sexual & Reproductive Health*, formerly the *Journal of Family Planning and Reproductive Health Care*, Jane Hatfield, FSRH chief executive, and Dr Asha Kasliwal, FSRH President, say they welcome a broad range of views among their membership.

Patients and healthcare professionals can only benefit from environments in which practitioners are open about their beliefs, they add.

Those clinicians who don't feel they can provide abortion or contraceptive services because of their personal beliefs would not be barred from membership of the Faculty, they emphasise.

But they have to be prepared to ensure that the needs of their patients come first as these are paramount, say the authors.

"The heart of the new guideline is that we welcome members with a range of views," they write. "And we will award the relevant Faculty qualifications to those who fulfil all the training requirements and are willing to show that they will put patient care first, regardless of personal beliefs."

The first set of guidance for trainees, produced in 1999, recognised the legal right of healthcare professionals in the UK to opt out of abortion care.

When the guidance was updated in 2014 to include nurses, who by then had become eligible for Faculty membership, the chief executive of the Christian Medical Fellowship challenged it.

He accused the FSRH of discriminating against Christian doctors, because the guidance stated that healthcare professionals must be able to provide all forms of contraception in order to be awarded the Faculty's diploma. His stance was backed by certain people in the US and by some UK MPs.

The FSRH felt its position was "entirely reasonable," but the challenge gave it "pause for thought," say Hatfield and Kasliwal.

Discussions with the membership brought to light a spectrum of views, from overt conscientious objection to abortion care or fitting intrauterine devices as emergency contraception, through to a belief in 'conscientious commitment' to responding fully to a woman's needs, regardless of personal beliefs, and a recognition that beliefs can change over a clinician's lifetime.

"Finally we arrived at the key principle that a patient should never be put at any disadvantage as a result of the views of any healthcare professional they see," write the authors.

The 2017 guidance therefore states that any clinician wishing to opt out of care because of personal beliefs would have to agree to reveal these to their service or employer, so that alternative arrangements could be made for patients, and that those arrangements should in no way imply a value judgement about those patients.