

The FSRH guideline on conscientious objection disrespects patient rights and endangers their health

We write to offer feedback on the new Faculty of Sexual & Reproductive Healthcare (FSRH) guideline¹ on conscientious objection (CO) that was the subject of an editorial² in the January 2018 issue of this journal. Our position, for which we have a clear evidence base, is set out below.

Essential parts of the new FSRH guideline,¹ as well as the reasoning behind it, contradict the available evidence around the practice of CO, so we predict that the guideline will largely fail in practice.

We have written extensively on the problem of so-called CO in reproductive healthcare.³ The available evidence clearly shows that CO is a violation of medical ethics and patients' rights, has no place in reproductive healthcare, and has misleadingly been co-opted from military CO. CO in healthcare is about imposing one's religious or personal beliefs, including any negative consequences, on vulnerable others. This is the opposite of military CO. Refusing medical care based on personal beliefs is a negation of evidence-based medical practice and a repudiation of the overriding goal of medicine – to care for patients.

The FSRH authors² cite the CO clause in the UK Abortion Act 1967 as legitimating non-participation in abortion care, as though that law justified the practice of CO against women with an unwanted pregnancy, when such a discriminatory practice is not tolerated for any other group of patients.

In November 2017, we presented oral evidence against the CO clause in the UK Abortion Act 1967 to the UK All-Party Parliamentary Group on Population, Development and Reproductive Health. We explained that the historical basis of the CO clause had been to satisfy the Catholic Church (David Steel, personal communication, October 2017), in our view an illegitimate reason. We gave examples of harms, including 45 instances of death or serious injury/injustice, arising from refusal to treat under CO⁴ and urged the UK to repeal the entire law or at least the CO provision.

The six ethical questions raised during the FSRH review arbitrarily assume that CO in healthcare is a right. We suggest the FSRH review should have included

reasons to restrict or ban CO in reproductive healthcare as a violation of patients' rights, and that this evidence-based viewpoint⁵ was overlooked.

We would like to offer our own answers to the ethical questions raised in the FSRH review as detailed below.

1. The rights of the healthcare professional (HCP) cannot be balanced with the rights of the patient – the rights and interests of patients should always prevail.
2. HCPs should have to disclose their beliefs to everyone if these beliefs impair their ability to fulfil their professional duties. They should not accept a job, or should leave the job, if their beliefs make it impossible for them to do that job.
3. If their views change, newly objecting HCPs should be required to participate in values clarification workshops to educate them on the need for contraception and abortion. Continuing objectors should be disincentivised, transferred, or have their employment terminated.
4. Objectors should be held liable for harms they cause to patients as is the case in any other aspect of medicine. They should be monitored and held to account by the FSRH, for example through registration, auditing, and reporting on refusals of care. The FSRH should impose necessary sanctions such as termination of employment, demotion, or loss of licence.
5. HCPs choosing the specialty of sexual and reproductive health (SRH) should be expected to deliver all forms of contraception and abortion care. Employers should have the authority to hire non-objectors over objectors.
6. It is not the responsibility of health services to make HCPs who put their own beliefs before patient care feel safe. These individuals should be screened out of SRH, re-educated, disincentivised from conscientious objection, or helped to transfer to a discipline where their objection will not be a problem.

We would urge the FSRH to rethink its new guideline and implement enforcement measures, with a view to reducing the number of HCPs

refusing to treat patients under the guise of CO, and eventually eliminating them from the specialty.

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