

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

We are grateful that the authors of this letter¹ have taken the time to critique the guideline² published recently by the Faculty of Sexual & Reproductive Healthcare (FSRH) on personal beliefs for those undertaking Faculty qualifications. One of the lessons we have learned over the last 2 years of discussing this issue with our members is that it deserves to be debated far more openly than is currently the case in the UK. We hope that correspondence and debate about the guidelines in *BMJ SRH* will encourage this.

The first point we would make is that the authors' letter¹ appears to be based on a misunderstanding of the role of the FSRH. The Faculty is not a regulatory body. We have no power or right "to impose necessary sanctions such as termination of employment, demotion, or loss of licence". We are a charity providing training and education and clinical guidance in the field of sexual and reproductive healthcare (SRH). Our aim in revising our guideline was to address the issue of whether a doctor or nurse with personal beliefs that might lead them to refuse to prescribe, for example, some forms of emergency contraception, should be able to undertake any of our qualifications. The majority of our members are healthcare practitioners (HCPs) working in primary care whose sole focus is not necessarily reproductive healthcare.

Despite the highly critical tone of the 'feedback' offered by the authors, there are many points on which we agree with them. For example, our guideline is designed to encourage HCPs to be open about any personal beliefs that could affect patient care or choice, an opinion shared by the authors. Equally we would agree that it would be extremely beneficial if all HCPs could, in their professional training, do 'values'-based training that enables them to reflect on how their personal beliefs might impact on patient care, even if unconsciously. Third, we would agree that any HCP who declares a 'conscientious objection' (CO) to abortion care delivery and who chooses obstetrics & gynaecology or community SRH as a specialty should have to observe consultations on abortion/pregnancy

choices so they can personally experience the narratives from women faced with unintended or unwanted pregnancy and therefore cannot be ignorant about the reality of the need for these services. Finally, there were members of our Conscientious Objection Working Group who expressed the view that the concept of 'conscientious objection' in healthcare is out of date and highlighted that 'conscientious commitment'³ might be a better framework within which to address these issues. Conscientious commitment inspires the HCP to deliver treatments to women's healthcare needs giving priority to patient care over adherence to their beliefs.³ However, it was agreed to take UK law as a given for the purposes of updating our guideline. This does not rule out the Faculty taking a stance on what it feels may need to be changed in the legal system in the future, as we have demonstrated on our recent stance on support for decriminalisation of abortion.⁴

Where we differ from the authors is in suggesting that HCPs with personal beliefs that could lead them to refuse to carry out abortion care or prescribe all forms of emergency contraception should be "weeded out", "disciplined" or that we must "eliminate them". This might work in a highly authoritarian regime but we are a multidisciplinary membership body that encourages its members to put patients first. By taking the lead among professional medical membership bodies in openly debating and addressing the issue of conscientious objection and the impact of personal beliefs, we want to encourage HCPs to feel safe to speak up about their beliefs and genuinely explore how they could impact on others – both patients and colleagues. Any other approach – particularly those advocated by the authors – would, we believe, continue to drive the problem underground. That has gone on for far too long in the UK and we hope that our guideline and the debate around it will encourage constructive discussion that will benefit all.

The Faculty is committed to continuing to debate the issues raised by personal beliefs and conscientious objection in SRH, and trust that this will include the perspectives and expertise of the authors of this and other responses to our guideline.

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