LETTER TO THE EDITOR

Conscientious objection to abortion

The editorial and papers in the June 2016 Journal on conscientious objection to abortion [1–3] raise many interesting points. Can I suggest that the issues are wider and deeper than those discussed? There are at least two questions, which are as follows:

1. Does abortion need to be ‘the province of an Ob/Gyn’[1] and does it always need to be hospital based? In other words, is the objection to abortion by healthcare practitioners (HCPs), of many faiths (many who are Roman Catholics, evangelical Christians, Muslims and others) or no faith, really the main cause of barriers to access or do we need to look at barriers in the legal and public health systems?

2. Is abortion the only ethical issue that our specialty faces and (as discussed in editorial) [2] given the present political climate can reproductive health afford not to have HCPs who are prepared to follow their consciences?

Barriers to accessing abortion

The right of women to receive care and to have autonomy is indeed paramount, but many of the current barriers to abortion care may be due to legal and organisational systems rather than clinicians’ beliefs. For example

1. Most early abortions can be done by the medical method and so do not need full hospital care (although emergency back up is needed). Various models of community-based provision have been tried [4,5] in the United Kingdom, these have been hampered by the purely legal requirement for the woman to return to the clinic to receive her misoprostol (although women who are miscarrying are allowed to take the same medication home with them). Abortion could be undertaken by a much wider range of HCPs than the traditional Ob/Gyn, for example community-trained doctors, GPs, nurses and midwives. The imposition of a requirement for abortion clinicians to have full hospital admitting privileges in Texas caused a serious drop in the availability of the procedure.[6]

2. Autonomy may be reduced by the need for an initial professional referral; in parts of the United Kingdom, self-referral by phone to a central booking service has been found to be efficient and appreciated, by passing the wait for a primary care appointment. A woman using this service knows that she will have her first clinical encounter with HCPs who have made a positive decision to work in this field (as opposed to HCPs who have to undertake procedures that they regard as distasteful or worse in order to work in gynaecology). Counselling is of course always needed for
those women who find the decision difficult.

Does Europe need HCPs who will listen to their consciences?

The political climate in Europe (in July 2016) is changing rapidly, there is a distinct possibility of less liberal governments [7], possibly leading towards coercive contraception or the spread of eugenics. If this happens, we will need HCPs who are able to think for themselves. This may be disobedience, but whether it is dishonourable [1] is not for the ESC to judge. In the United Kingdom, some of the first steps towards a safe and legal abortion service were taken in 1938 by a gynaecologist who aborted the pregnancy of a 14-year old who had been raped, and then he stood trial. If the legal case had gone against him, he could have faced penal servitude for life.[8] This was brave and surely not dishonourable. Finally, as physician-assisted suicide becomes debated [9] and more accessible, abortion may not be the only contentious ethical issue. Will oncologists, including gynaecological oncologists, be having similar discussions in a few years’ time?

Disclosure statement

Lesley Bacon was a consultant in sexual and reproductive health care in a deprived area of London until she retired in January 2016. She performed medical abortions and managed a service for EMA in a community setting. She is a member of the Religious Society of Friends (Quakers).

References

致编辑的信

出于良知反对堕胎

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2016年6月杂志刊登的《出于良知反对堕胎[1-3]》的编者按与论著提出了很多有趣的观点。我是否可以提出几点比这些讨论更广更深刻的见解？至少有如下两个问题：

1、堕胎是否需要被划分在“妇产科学领域”[1]以及它是否始终需要基于医院？换句话说，有信仰的（如罗马天主教徒、福音派基督徒、穆斯林等）或无信仰的医疗从业人员（HCPs）反对堕胎是否真的是造成或被我们视为法律与公共卫生系统之间障碍的主要原因？

2、堕胎是否是我们专业面和（正如编者按所讨论）[2]鉴于目前的政治环境生殖健康可以承受不具准备随他们良知的HCPs唯一的伦理问题？

堕胎实施的障碍

女性获得健康和自主的权利确实重要，但目前很多流产医疗面对的障碍来自法律和组织系统，而非临床医生的信仰。例如：

1、很多早期流产可以通过药物方法完成，所以并不需要整个医院的医疗参与（尽管需要急诊作为保障）。英国曾尝试过多种基于社区的模式[4,5]，但纯粹是因为法律要求带来的阻碍，使得女性不得不返回到医院才能获得米非司酮（虽然流产女性被允许在家中服用这类药物）。堕胎可以被更大范围的HCPs实施而不局限于传统的妇产科医生，比如经过培训的社区医生、全科医生、护士和助产士。

在德克萨斯州，对于人工流产医疗从业者需通过全医院允许特权的招募要求导致程序的可行性严重下降[6]。

2、初级专业转诊可能会降低自主性。在英国某些地区，绕过初级保健预约的等待，通过电话向某个中心预约自我转诊被证实高效而且获得好评。一名女性使用该服务可以得知，她将要到在这个领域工作的做正面决定的HCPs那里进行她的第一次就诊（相反，其他HCPs不得不在妇科工作而进行他们认为反感或更糟的操作）。对于那些难做抉择的女性来说，咨询当然总是非常重要的。
Europe: Is it necessary to listen to the moral HCPs?

Europe's political climate in July 2016 became dramatically different, encouraging a more liberal government that might significantly reduce the number of religious objections[7], perhaps even spreading contraception or eugenics. If those become a reality, we will need HCPs who can think for themselves[8]. This might be seen as rebellion, but whether it is rebellion is not something that ESC can decide[9].

In the UK, abortion became legal in 1967, when a gynaecologist performed an abortion on a 14-year-old girl who had been raped. If the law had been against it, he might have faced lifelong imprisonment[8], but this was brave and certainly not dishonorable.

Eventually, when "doctor-assisted suicide" became a debated topic[9] and increasingly understood, abortion might not be the only matter related to moral ethics. In recent years, oncologists, including gynecological oncologists, will have to engage in a similar discussion?

Statements

Lesley Bacon is a London community sex and health advisor who retired in January 2016. She ran a local clinic where women received drug abortions and managed EMA services. In addition, she was also a member of her country's religious society (Quakers).

Reference