Response to: 'Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies' by Schuklenk and Smalling

Richard John Lyus

ABSTRACT
Bioethicists commenting on conscientious objection and abortion should consider the empirical data on abortion providers. Abortion providers do not fall neatly into groups of providers and objectors, and ambivalence is a key theme in their experience. Practical details of abortion services further upset the dichotomy. These empirical facts are important because they demonstrate that the way the issue is described in analytical bioethics does not reflect reality. Addressing conscientious objection as a barrier to patient access requires engaging with those who provide the service and those who are able to but do not. The experiences of doctors facing these decisions potentially challenge and expand our understanding of the issue as an ethical concern.

In the April edition of *JME*, Schuklenk and Smalling[1] laid out a broad argument against permitting conscientious objection in healthcare. The paper deals with conscientious objection in healthcare in general, but addresses abortion in a substantive way. I want to respond to the paper as it relates to this specific issue. My paper may or may not have relevance to other healthcare services for which conscientious objection is a consideration but here I leave that up to the reader to determine.

Bioethicists writing on conscientious objection as it relates to abortion care, and who are concerned about the impact this has on patients, should consider the relevant empirical reports. In contrast to the impression one might get from reading Schuklenk and Smalling's paper, abortion providers do not divide neatly into those who provide and those who object. This is one of many important details that are lost in analytical bioethical discourse that addresses the issue. These details are important if one is concerned with remedying the problem of conscientious objection as a barrier to patient access, but also because these details develop our understanding of ethics more broadly considered.

Contrary to the dichotomy of provider-objector employed by Schuklenk and Smalling, and others who have argued against conscientious objection, the empirical literature on the experience of abortion providers shows a consistent thread of ambivalence. In 1980, Hern and Corrigan reported a survey of staff at an abortion clinic, which found that most respondents were 'considerably ambivalent about D&E' (dilatation and evacuation, the most common method of second trimester surgical abortion) and demonstrated the complex reactions of staff, which included emotional responses, disturbed sleep, negative effects on relationships and dreams of vomiting up fetuses. The lead author—who remains a pre-eminent campaigner for abortion rights—concluded the report by saying:

> No-one who has not performed D&E can know what it is like or what it means; but having performed it, we are bewildered by the possibilities of interpretation […] The sensations of dismemberment flow through the forceps like an electric current […] It is the confrontation with a modern existential dilemma.[2]

Decades later, Harris published a similarly personal reflective piece in which she commented that surgical abortion involves violence, which would normally be anathema to the feminist movements with which she felt herself to be aligned. She went on to state, however, that she remained committed to providing the service.[3] Harris has also written about how the terms of the conscientious objection debate obscure the fact that provision might equally be grounded in conscience.[4]

While D&E may be a particularly challenging type of abortion to provide, the concerns it raises are relevant to all methods and at all gestations for at least two reasons. The first is the empirical data. A recent report of obstetrics and gynaecology trainees by Singer *et al* addressed abortion care in general. The experiences of those studied were as complex as those I have described above, with one physician describing conflicting feelings that lead to 'an abyss of ambiguity' in her efforts to decide whether she would include abortion in her scope of practice. The authors summarise as follows:

> The decision on the part of obstetrics and gynecology [doctors-in-training] to opt in or out of abortion training is, for many, a complex one. Although the public debate surrounding abortion can be filled with polarizing rhetoric, [doctors-in-training] often discover that the boundaries between pro-choice and pro-life beliefs are not so neatly divided. Our objectives in this commentary are to encourage a more nuanced discussion […] and to demonstrate that the clear distinction between being pro-life and pro-choice often breaks down when one is immediately responsible for the care of pregnant women.[5]

Second, notwithstanding the widely held intuition that more developed fetuses warrant greater moral respect than earlier fetuses, I would suggest that the feelings evoked by second trimester procedures—which are notably less widely supported than first trimester procedures—can help us better understand the feelings of those who are opposed to abortion outright.

It is worth noting that the complex and conflicted experiences of doctors who provide abortion are similar to those of many women who undergo abortion[6–9] and also those of healthcare professionals involved in fertility services whose work involves manipulating and discarding embryos.[10–12]

There are a variety of practical details related to abortion provision that further upset the dichotomy: some providers may only perform abortion for specific reasons, such as fetal anomaly or maternal illness; some may only provide abortion to a particular gestation; some may only provide certain methods of abortion;[13] some may request certain practices be in place to morally enable them to perform abortion, such as formal preoperative counselling or killing of the fetus by injection prior to the commencement of the abortion procedure; some may be motivated to provide abortion but be concerned about stigma[14] or being the target of antiabortion journalists; some may

Correspondence to Dr Richard John Lyus, Visiting Scholar, Oxford Centre for Life Writing, University of Oxford Wolfson College, Oxford, Oxfordshire, UK; richlyus@gmail.com

worry about being victims of antiabortion violence; some may have concerns about being vulnerable to prosecution if abortion is regulated by criminal law, as in the UK. These are all problems that raise legitimate concerns for those considering providing abortion care, and which must be negotiated with little or no formal support, in the context of a wider professional and personal life. Between provision and objection, there are a variety of positions that involve such a diverse range of considerations and consequences that they do not even lend themselves to being considered as anything so ordinal as a spectrum. This tells us that it is not just *whether* we perform abortions that matters, but also *how* we perform abortions, by which I mean any of a variety of considerations, ranging from one's operative technique, to location of practice, to the relevant legal frameworks in which practice is embedded.

Schuklenk and Smalling might argue that the empirical details are not relevant: one either provides or does not, and 'choosing to join a profession is a voluntary activity undertaken by an autonomous adult'. They argue that all doctors are free to not join the profession in the first place or leave the profession if they decide they are unwilling to undertake care that society has determined to fall within their scope of practice and over which they have a monopoly. However, the reason doctors have a monopoly on abortion is because they are uniquely qualified to perform the procedure, not because they are uniquely qualified to make difficult moral decisions (and I am including here both the moral decision to provide abortion and/or the decision to devolve one's moral decision-making about providing abortion to others). Doctors are no more qualified in this respect than anyone else, yet they remain uniquely morally accountable. It seems unrealistic, and unfair, to suggest that a 17 year old applying to medical school, or a 23 year old applying for postgraduate training in obstetrics and gynaecology, should be expected to have drawn concrete conclusions about moral issues that are riven with the complexities described in earlier paragraphs and that have been intractable to the efforts of a large body of philosophical thought extending back at least to the time of Cicero. Educational initiatives designed to expose medical students to women requesting abortion are promising in this regard[15] and offer students a chance to engage with the issue outside of (or alongside) the frameworks of analytical ethics. Such exposure should arguably be an obligatory element of medical education in order for decisions about objection or provision to be made conscientiously.

Some of the responsibility, then, falls upon educational institutions and professional bodies. In this regard, before one points the finger at doctors, one is obliged to ask: What is the empirical data? What do we know about medical school and postgraduate medical training in abortion and other controversial healthcare? Are these institutions doing a good job of both helping doctors to make difficult moral decisions and supporting doctors to live difficult moral lives? Have we even considered what 'doing a good job' would look like in this context? (Who can tell someone what it means to wake up from a dream in which one vomits up a fetus?) When doctors don't provide abortion care, or certain types of abortion care for certain patients, it does pose serious problems for service delivery and affect the care patients receive.[16] However, it seems rather too convenient for bioethicists to simply suggest that doctors are shirking a duty, and one that should be obvious.

Some responsibility must also fall upon bioethics. That those bioethicists who are so convinced of the rightness of abortion have failed to develop a discourse that builds consensus among the doctors whose work they seek to regulate is as much an indictment of bioethics and its relationship with clinical practice as it is of the ostensible lack of professionalism among doctors. But unfortunately, rather than collaboration between the modes of discourse, accusatory rhetoric is increasingly prevalent in the discussion of conscientious objection. One would prefer to avoid being drawn into the fray. However, it seems important to consider, for example, the following comments in Schuklenk and Smalling's paper:

> Given the intractability of conscience claims, it is not unwarranted to characterise them as essentially arbitrary dislikes. They might not be arbitrary in the eyes of the objector, but we cannot even be certain of that, given our inability to test the objector's conscience claims.

Such concerns sound to me needlessly confrontational. The authors have not even considered what the reasons for conscientious objection might be, beyond drawing on one paper, which reported that "the vast majority of litigated cases are triggered by religious conscientious objectors as opposed to secularists or atheists". It is hard to see how this specific group (litigated cases), taken in the context of all services to which doctors might conscientiously object, can be considered representative of providers who choose not to provide a particular service—especially for those objections that do not reach the level of litigation. Indeed, in the face of the empirical data presented in the preceding paragraphs, it seems likely that it certainly is not representative, at least in the case of abortion.

It is unfair to suggest that this kind of language is exclusive to Schuklenk and Smalling, when it is simply the form much analytical bioethics takes. However, with its apparent lack of interest in the experience of providers of abortion services, and its quickness to despair that conscience claims are untestable, one questions whether analytical philosophy in this mode has much more to contribute to the debate on conscientious objection, beyond, that is, providing a stick with which human resources departments can beat their clinical employees. I hope it can contribute something more, but must admit I do not see much potential in the most recently published—and most prominent—articles. I look forward to being proved wrong.

What may be more fruitful, both in terms of addressing the issue of provider shortages and deepening our understanding of how doctors use ethics in practice, is collaborative and interdisciplinary empirical research. This would involve endeavouring to understand why some doctors provide abortion and why some do not, a process that, undertaken in earnest, might require the investigators to challenge their own understanding of how moral problems should be constructed and what is morally relevant. The papers cited in earlier paragraphs provide an example. The empirical reports demonstrate that there are legitimate problems and concerns that doctors face in considering abortion provision, which are not generally arbitrary or in pressing need of testing for validity. What doctors require is dialogue and support rather than discipline and punishment. They should be empowered to provide, or object, in evermore conscientious ways. This means that conscientious objection would not only be accepted, but that our efforts as ethicists would necessarily shift from wondering how we could challenge and interrogate a doctor's views, to making sure we had done as much as possible to help that doctor reach those views in a considered way.

The final concern I want to raise is at once more personal and more cultural. The position of Schuklenk and Smalling is

one that demands individuals to devolve moral decision-making to a forum separate from that in which the moral act takes place. This forum might be at the level of managers, regulatory bodies or philosophical discourse, for example. When very serious questions of violence and destruction of life are concerned, I find this proposal concerning. Such a way of practising could become profoundly alienating for the doctor, for it requires that she or he work in a moral vacuum, maintaining a perfect neutrality in the face of killing. Such a neutrality should be of concern to all of us, not just the doctors involved, because it highlights the degree to which abortion is narrated through ideology rather than reality. It is perhaps possible to read Schuklenk and Smalling's position as an extension of a particular type of Cartesian rationalism in which unthinking machines (doctors) destroy machines without capacity for thought (fetuses) on behalf of idealised rational agents. I don't think such a reading is hyperbolic, for the point is simply that the scepticism the authors express about the importance of individual conscience claims cuts both ways, with implications for providers, objectors and everyone else. As Paula Lee Young writes in *Meat, Modernity, and The Rise of the Slaughterhouse*, how we kill reveals how we keep our belief systems alive.[17]

As an alternative, one might suggest that engagement with the moral substance of one's actions is an essential element of how one builds value around, and comprehends, one's clinical practice. This 'moral work'[10] seems to me an essential part of making sustainable, and making sense of, those services that contravene one's most deeply held intuitions about obligations to fellow beings. Furthermore, moral work should be seen not just as a reparative process to manage challenging psychological reactions, but as an essential element of providing services in a moral way, at an individual, organisational and societal level (institutions can be judged by the individual lives they cultivate). The expanding body of work on moral distress and its related concepts is a step in the right direction, yet we have barely scratched the surface of understanding moral experience in this context or considering its normative importance.

Simone de Beauvoir wrote that "morality resides in the painfulness of an indefinite questioning". This process of indefinite questioning is very much a part of my own inner life as an abortion provider. Inner lives may be considered by some to be irrelevant in ethical terms, particularly if all one cares about is whether an individual provides a service or does not. Those of us who work in abortion services—and probably those who don't—may beg to differ.

Twitter Follow Richard Lyus at @RJLyus

Competing interests None declared.

Provenance and peer review Not commissioned; externally peer reviewed.

To cite Lyus RJ. *J Med Ethics* 2017;**43**:250–252.

Received 14 December 2015
Revised 27 June 2016
Accepted 23 July 2016
Published Online First 16 August 2016

J Med Ethics 2017;**43**:250–252
doi:10.1136/medethics-2016-103643

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17 Young PL, ed. *Meat, modernity, and the rise of slaughterhouse*. University of New Hampshire Press, 2008 (my analysis in this paragraph borrows heavily from this excellent work, particularly the three chapters contributed by the editor and the chapter contributed by Chris Otter).