The dishonourable disobedience of not providing abortion

Letter to the Editor

European Journal of Contraception and Reproductive Health Care
Joyce Arthur, Christian Fiala, Kristina Gemzell Danielsson, Oskari Heikinheimo & Jens A. Guðmundsson
Page 1 | Received 08 Oct 2016, Accepted 13 Oct 2016, Published online: 04 Nov 2016

- Download citation
- http://dx.doi.org/10.1080/13625187.2016.1250255
- Crossmark

We thank Lesley Bacon for her response ('Conscientious objection to abortion', *EJCRHC*, 2016;21:5;414–415) to the papers in the June 2016 Journal on conscientious objection. As authors of one of these papers ('Yes We Can! Successful examples of disallowing "conscientious objection" in reproductive health care', *EJCRHC*, 2016;21:5:201–206), we would like to address the points she raises.

We agree with Dr. Bacon that if we ever see the return of human rights violations like coercive contraception or eugenics, we will need HCPs with a conscience to be disobedient to such practices, and that would not be dishonourable. However, the type of conscientious objection that qualifies as 'dishonourable disobedience', is where an HCP refuses to provide a legal medical procedure that the patient *requests and needs*, not something imposed upon her. Also, providing a stigmatized or even illegal treatment that the patient requests and needs – such as safe abortion – is an act of 'conscientious commitment', a term coined by Canadian ethicist and legal scholar Dickens.[1 Dickens B. Conscientious commitment. Lancet. 2008;371:1240–1241.[CrossRef], [PubMed], [Web of Science ®]] Refusing to provide a treatment that is harmful, coercive or done without patient consent, would be true conscientious objection (examples are torture or infant/child genital mutilation).

Dr. Bacon also questions whether conscientious objection is really the main barrier to abortion care, when legal and organisational barriers are also major contributors. She points to examples of laws that reduce access, and also suggests that if abortion was done by a much wider range of HCPs, not just obstetricians/gynaecologists, this would greatly improve access.

It is certainly true that abortion access is hampered by many legal and organisational barriers, and we agree that conscientious objection is not the only barrier, although it is a major problem in some regions and the hugely negative consequences for women cannot be ignored. Further, we would point out that most if not all barriers to abortion care are either the result of stigma (such as criminal laws), or are worsened by stigma, including how abortion practice tends to be limited to mostly obstetricians/gynaecologists. Expanding the field of abortion care to other HCPs such as nurses and midwives is a necessary and welcome reform, and has been shown to be safe, well accepted and cost effective, as implemented in Sweden.[2,3 Kopp KH, Gomperts R, Salomonsson E, et al. The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: a randomised controlled equivalence trial. BJOG. 2015;122:510–517. Sjöström S, Kopp Kallner H, Simeonova E, et al. Medical abortion provided by nurse-midwives or

physicians in a high resource setting: a cost-effectiveness analysis. PLoS One. 2016;11:e0158645.] However, making that happen is challenging in many countries because of abortion stigma and politics.

While stigma negatively impacts almost every aspect of abortion care to some degree, ‘dishonourable disobedience’ is a form of full-blown, officially-approved stigma, which makes it particularly unsupportable, especially when abortion access is already curtailed by stigma in so many other ways.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this letter.