Victorian Rural Clinical Network Meeting 13 October 2020

Summary Notes provided by Cath Hannon, The Women's Clinical Champions Project

Snapshot of 1800Myoptions

Number of callers has been stable.

Profile of callers:

- Due to COVID-19 increase in level of financial insecurity experienced by callers seeking abortion and contraception services, therefore increased demand for bulkbilling services
- Increase in number of women presenting with a pregnancy in later gestation throughout COVID-19. Reflects a level of pre-occupation and fear about accessing services.
- Regular reports from callers of being obstructed in their attempts to access an abortion service. Typical scenario is a GP who creates barriers such as time delay before referral made, challenging the women's decision making "go home and think about it", misinformation about eligibility. 1800MyOptions maintain a database of these scenarios. Consistently occurs across all regions - metro, regional and rural. Recent scenario of a provider who acknowledged they were a conscious objector to abortion but recognised need to provide a medical abortion service for the woman concerned. The service provider contacted 1800Myoptions for an appropriate service to refer to in order to meet the GPs legal obligations.

Discussion on the need to improve health literacy targeting potential and actual service users about access to services and information about sexual and reproductive health issues. Not all services require a GP referral to access a S&RH service. Discussed opportunities to increase level of S&RH information available to the community in order to improve their knowledge, awareness of options available. An example of this work is the 1800Myoptions recent social media campaigns promoting information about medical abortion as a choice of method.

Presentation by Dr Paddy Moore, Clinical Lead Vic Rural Clinical Network.

A Conscious Commitment: a morality tale in 3 slides, how to discuss issues of conscience with colleagues and trainees

Presented as a series of scenarios.

Scenario 1: The interview.

Story context. Huan is a GP Registrar who applies for a job at a Sexual & Reproductive Health (S&RH) hub. At the job interview Huan states they are prepared to offer all aspects of S&RH except abortion.

Discussion points

How to approach this? What questions would encourage discussion and understanding of Huan's position while gently challenging their standpoint.

- Explore spectrum of willingness to be involved in various components of care, i.e. involved in work up and referral to another service and provide follow up but not provide the script.
- Over time and with a developing understanding of the context of individual woman's lives, Huan may reach an understanding of the need to be directly involved in abortion care. Particularly important in rural context as there are fewer providers.

- The need to be curious about Huan's position. Could sensitively and respectfully probe her position that aspects of S&RH care are acceptable and some are not. Gently ask her to articulate the thought process behind their standpoint.
- Even though abortion is a known taboo, rather than simply accept their position it is possible to sensitively encourage these discussions. Initiating a conversation to articulate their position is an important component of moral/ethical development.
- Use this conversation as an opportunity to open up about one's own moral/ethical development and reflect on this position and the development throughout S&RH career. Share these reflections with Huan.

Scenario 2: The consultation.

Story context. Huan is offered the S&RH position for probationary period. Sits in on a consultation and this is an opportunity to hear women's stories.

Huan's background: Vietnamese ethnic group, attended religious schools, 4 children in family, 3 are professionals, 4th child has severe disability, parents full-time carers. At university involved in Christian union, exposed to opposition to abortion based due to religious teachings. Huan reflects on the impact and challenges associated with living with a severely disabled sister.

Josie, the patient in the consultation- 23yo, G1P0, 14/40 gestation, unplanned pregnancy, initially welcomed and accepted the pregnancy. However, now experiencing increasing intimate partner violence (IPV) during the pregnancy. Has made a decision to leave the relationship and to relocate interstate to be with her mother. Past history of childhood physical abuse, previous IPV.

Discussion points

Provide an opportunity to reflect on Josie's story. What is it like to be in this woman's shoes? What feelings came up for you as you listened to the patient's story?

- Set up opportunities for discussion with Huan. This is not an uncommon story to those who work in S&RH, however this could be a new scenario for Huan who may have had limited exposure to unwanted pregnancy and associated complexities.
- The consultation is an opportunity to reflect on how Josie's trauma background has impacted on her and shaped her current life situation and choices.
- The potential may be to blame the patient and the domestic violence situation Josie is in and that it repeats a pattern from her past. Huan's conclusion may be - what would the abortion solve, it doesn't fix the intimate partner violence"?. Create opportunity to challenge this possible standpoint.
- Opportunity to inform the clinician of trauma informed practice and the long-term consequence of experiencing trauma.

Scenario 3: The phone call

Story context. Huan receives a phone call from her brother. Brother and partner now 13 weeks pregnant, NIPS test, indicates high risk for Trisomy 21. The brother reflects on impact of growing up with a severely disabled sibling and impact on relationship with parents. The brother states he doesn't want to repeat a similar scenario for himself. He seeks Huan's advice.

Discussion points

- Acknowledge and validate difficulty and complexity of the situation and decision-making process.
- Everyone has a story that has led them to the decision they have made. Have the person's story front and centre, to set aside the other (Huan's) perspective.

- The conclusion may be a decision that is “right enough” in the circumstances or a “good enough” decision in a tough situation.
- The health professional role is to actively listen, to seek to understand, to trust and honour the patient’s story.
- Opportunity for the S&RH hub workforce to actively open up conversations and engage with the S&RH workforce and students to educate and promote discussion of conscientious provision of S&RH services.

Further Reading:

Watson, K 2019. Abortion as a moral good. The Lancet, Vol. 393, No. 10177, p1196–1197.

PDF attached.

Service update:

Swan Hill District Health now providing a medical abortion service. Nurse-led service delivery. Listed with 1800Myoptions.

The art of medicine

Abortion as a moral good

My medical students first hear from a family physician who describes himself as pro-life. He's Christian, and his faith is "a large part of the reason" he refuses to perform abortions. "Christ says things like do to others what you want them to do to you, or love your neighbour as yourself, and when I'm in the room with a pregnant patient I think I have two neighbours in there", he tells the second years. Then they hear from an obstetrician who specialises in abortion care. She too is a Christian, and some students look surprised when she says her religious beliefs are one reason she sought fellowship training in abortion. "Do unto others as you want done to you, always take care of your fellow man. When a woman needs help, I want to help her. So I take those sayings and teachings to mean that God would be very proud of me", she explains. These two physicians then take questions together, interacting in a friendly way as each commends the other's deep commitment to patient care. Once they leave, I use the case studies they provided to focus attention on the medical ethics of conscientious refusal and conscientious provision of health care.

After hearing professors say it's impossible to teach a productive class on abortion and physicians say it's impossible to mediate staff disputes on the topic, I value the way this session disrupts the stereotype that people who disagree can't talk about abortion. However, it's hard to picture the secular ethics version of this collegial classroom exchange happening—and because mainstream medical ethics has become a largely secular enterprise in the USA, as a bioethicist that troubles me.

One reason is that in abortion care, morality is usually equated with religion. When abortion was illegal in the USA, religious voices spoke on both sides. During the 1960s, some ministers and rabbis of Protestant and Jewish denominations openly decried abortion's criminalisation as immoral, and the Clergy Consultation Service that formed in 1967 referred pregnant parishioners to physicians who provided safe abortions in the years before the 1973 Roe *v* Wade Supreme Court decision legalised abortion across the USA. However, even in that era, people made the moral case in favour of abortion in both religious and secular terms.

Toya Sarno Jordan/Reuters

Today, the moral argument in the abortion debate—both religious and secular—is often perceived to be the province of those who oppose abortion. Opponents focus on fetuses and morality ("killing"), supporters focus on women and law ("choice"), and this disjuncture leads us to talk past one another. Yet working with health-care professionals who provide abortions has taught me that the shift in pro-choice discourse from ethics to law is a shift in rhetoric, not a shift in thought.

How might we correct the false impression that abortion opponents are the only ones thinking about the ethics of abortion? The first step is to remember that the conclusion women are full people entitled to self-determination begins as a moral argument and ends as a legal argument. Typically, consideration of the status of women is categorised as "legal" and consideration of the status of embryos and fetuses is categorised as "moral ," when really each of these analyses is both moral and legal.

The second step is to help people understand the secular ethics reasoning that leads those who support abortion access to conclude that abortion is either morally acceptable or morally good. In medical settings, this conversation might be destigmatised by articulating how the traditional medical ethics analysis of principlism supports abortion access.

The principlist analysis must address non-maleficence first—does abortion "do harm" to a person or a patient? This is the central disagreement of the physicians who speak to my class. People who think abortion is morally acceptable say it does not because they reject what abortion opponents call the "substantial identity" argument—ie, that people are intrinsically valuable because of what we are and that what we are is a physical organism that comes to be at conception because a fertilised egg contains the genetic blueprint for a human being. (A religious version of this argument substitutes "soul" for "DNA".) Instead, people who conclude abortion is morally acceptable think that qualities gained during pregnancy, such as the ability to think, feel, or survive outside the womb, are required to turn human tissue into a human being. They rarely claim that an embryo's potential to become a person (or its "latent qualities") is of no importance. But just as potentiality does not give an

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acorn the same value as an oak tree, they conclude that it is reasonable to put embryos and people in different categories.

Substantial identity and potentiality arguments often include a claim that a fertilised egg contains everything it needs to become a person. This is incorrect. To become a person, it also must be nourished by, and make a bloody exit from, a woman. This fact leads some to conclude that the central moral feature of pregnancy is that human development must take place inside a person's body. Assigning rational, sentient, biologically independent women a higher moral status than biologically dependent embryos or fetuses leads to the conclusion that forced childbearing is immoral, and that a woman's decision to end an unwanted pregnancy is a morally acceptable act.

Concluding that abortion does not violate the principle of non-maleficence makes it morally acceptable. This view explains why many pro-choice people see conception as a moral invitation rather than a moral obligation. "Moral" because whether to bring a child into the world is a value-laden decision of tremendous consequence to human health and happiness, and "invitation" because pregnancy is an opportunity for motherhood one may accept or decline.

Another secular ethics position is that abortion is morally good. This view is held by the health-care professionals who provide abortion care (they would not make it part or all of their life's work if they believed otherwise), and it is supported by the traditional medical ethics principles of autonomy, beneficence, and justice.

Clinicians who provide abortions honour the medical ethics principle of autonomy by helping their patients preserve bodily integrity, decisional freedom, and the dignity of dominion over their life's course. Childbearing dramatically alters a woman's identity and life experience, and in the USA childbirth carries a risk of death about 14 times higher than abortion. When a woman does not see enduring pregnancy and delivering a child as a benefit, an autonomy analysis respects her as a moral agent who is following her values, and allows her to decline the physical and social risks of childbearing.

Clinicians who provide abortions honour the medical ethics principle of beneficence by preventing the harms of forced childbearing and unsafe abortion. The principle of beneficence also illuminates some patients' abortion decisions as an expression of mother love. In the USA, 59% of abortion patients already have one or more children, and commitment to meeting their existing children's needs can contribute to their decision to decline nature's invitation to nurture another embryo to fruition. Similarly, when a young woman believes she can't yet be the kind of mother she wants her children to have, her abortion might be a beneficent act toward her future children.

Clinicians who provide abortions honour the medical ethics principle of justice in two ways. Abortion access is a component of economic justice because parenthood is expensive. In the USA, 49% of abortion patients have incomes below the poverty line and an additional 26% have low incomes; 73% of abortion patients list "can't afford a baby now" as one of their reasons, and 23% list it as "the most important reason". Until social programmes remove economic barriers to childrearing, allowing low-income women and families the option of abortion prevents them from being pushed even further into poverty. Abortion access is also essential to gender justice. Women have long been subjected to legal and social discrimination on the basis of their biological capacity for pregnancy. Today, the relatively new medical technologies of safe, effective contraception and abortion allow women to escape pregnancy's physical and social impact, and to come close to men's degree of sexual and reproductive freedom. Women cannot have social, economic, and interpersonal power comparable to men unless they can control whether and when they have children. Therefore, women's moral claim to equal opportunity requires access to abortion for pregnant women who want it.

Unprecedented political attacks on the character of clinicians who provide abortions in the USA have created an urgent need to communicate that every physician is a moral agent engaged in ethical decision making and acts of conscience in partnership with patients. In class, some of my medical students raise snippets of the secular moral arguments for and against abortion with the family physician and the obstetrician during their guest session. The students' comments and questions are sincere, and through them they engage with each other. The shoulders I saw tense forward for a fight when the family physician first said he is pro-life are relaxed; the shoulders I saw slouch dismissively when the obstetrician first said she sees nothing wrong with abortion are back at attention. Those who say we shouldn't talk about abortion because we're unlikely to convince each other have forgotten that sometimes we talk not to persuade, but to understand. In divided times, understanding is what prevents us from vilifying those who disagree, and retaining respect and compassion for patients and colleagues who see the world differently is central to the practice of medicine. I know my students won't remember every bit of content I taught in that session. But if they remember its spirit, perhaps the day they're told controversy makes any subject impossible to teach, or it makes any disagreement among medical staff impossible to mediate, they will politely disagree and take up the task.

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Further reading

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