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Original Research Article

Conscientious objections in medicine for abortions among the undergraduate medical students: a questionnaire-based survey

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ABSTRACT

Background: Conscientious objection (CO) in medicine is less a focused area of research in India.
Methods: In this questionnaire-based survey, responses from the students undergoing M.B.B.S./undergraduate training program from two medical colleges on voluntary abortion in general, and pertaining to the rape victims was obtained. We assessed the prevalence, influence of various factors and preference for referrals in CO towards abortion among the participants.
Results: Of the 900 students approached, 765 (85.0%) (females 68%) completed and returned the questionnaire, of whom 63.5% had an urban background, 48.0% were Christians and 52.0% were non-Christians (Muslim-5.4%; Hindu-46.5%). Only 9.7% had CO (p=0.000). There was a greater acceptance to abortion irrespective of gender and area of residence, except for gestational age beyond 20 weeks. Non-Christians were likely to have no objections towards abortion (p<005). Christians did not have CO for congenital abnormalities in pregnancy <20 weeks (60%), raped minor, (<20 weeks, 74%; beyond 20 weeks, 61%). Among the students who had CO, irrespective of religion majority had no issues with referring the woman to another doctor. The only exception to this norm was among the non-Christian students, who in case of raped minor <20 weeks were more likely (60%) to not refer.
Conclusions: CO is less prevalent among the Indian medical students and is towards voluntary termination of pregnancy, pregnancy beyond 20 weeks, when existed. Medical students were considerate towards rape victims. Religion plays a significant influential role in shaping the beliefs.

Keywords: Abortion, Conscientious objection, Religion, Referral

INTRODUCTION

Research in conscientious objection (CO) is one of the least focused areas in medicine but gaining momentum in the recent years. The dilemma arising from collision between the moral and professional integrity confuse a physician in executing certain medical decisions. Physicians are taught to consider patient's safety, offer medical aid without any prejudice. However, in certain situations there may be a conflict between moral commitment, religious beliefs and treatment to be offered. There is a debate if CO be allowed in medical practice, but with an inconclusive opinion, with few in support of not allowing to safeguard patient's right, safety and other physician's right.[1-4] There is an argument that there is no place for CO in medical profession, particularly in reproductive health.[5] There is a difference in global trend with certain countries (Sweden, Iceland, Finland, Bulgaria, and Czech Republic) not allowing CO; Italy allows CO but the medical practitioner has to register their objection.[2-6] Rate of CO varies between 15% (Australia) to 70% (Italy and Poland).[6,7] Majority of the countries follow a moderate path, allowing CO, but not during emergency and compromising patient safety.

In the absence of specific guidelines on CO, it is necessary to draw defining rules for the application of CO in clinical practice. As hospitals have an obligation to provide all medical services, the role of CO in institutions is limited.

Conscientious obligation is more evident to abortion as this is considered as an unforgivable sin. Countries have given consideration to CO to certain medical procedures, while others have banned it as most of the reasons for CO are based on non-assessable terms such as religious beliefs.[5] Most countries across the globe have legalized abortion, allowing medical termination of pregnancy (MTP) up to 24 weeks of gestation, describing who and when can be done. Few state CO as an excuse to reduce their workload, and it is often undermining a woman's right to reproductive autonomy, safety and right.

There is an increasing CO towards certain medical procedures among the medical practitioners globally; refusal to learn few medical procedures by medical students stating CO is an area of future concern. CO in India is a less discussed topic; as there are no studies available from India on CO among medical students towards abortion, this study assessed the same in our students.

METHODS

This questionnaire-based survey was conducted by the department of community medicine of a medical college from Southern India, after obtaining approval from the institutional ethics committee.

A pilot study was carried out which included 23 students of the IV term, 3rd year of a medical school. Time necessary for completion of questionnaire was noted. Feedback for modification was also elicited and ambiguous questions were reframed.

Subjects

All students undergoing MBBS/undergraduate training program from two medical colleges from a coastal city of Southern India were approached and questionnaires were handed to them in lecture halls during theory classes. A brief explanation of the study, the questions and instructions to complete the questionnaire was provided by a single investigator. Adequate time was provided for the students to complete the questionnaire based on their views on voluntary abortion in general and pertaining to rape victims, in particular. Basic demographic details of the participant were obtained. The time required for the completion of the questionnaire was ≈10-15 minutes.

This study aimed to assess CO towards abortion among the medical students and interns, influence of various factors and their views on referrals. The primary objective was to assess the prevalence of CO towards abortion among the participants; secondary objectives included evaluating on of the influence of various factors and preference for referrals in case of CO.

Statistical analysis

Data from the questionnaire was captured on MS Excel sheets (2007) and analysed using into statistical package for the social sciences (SPSS) V 23. Descriptive statistics was used; frequencies and percentages for descriptive data, with Chi square and Fischer's exact test being applied for statistical significance. Tables were used as appropriate.

RESULTS

Demographics

Of the 900 students approached, 765 (85.0%) completed and returned the questionnaire. There were 520 (68.0%) females and 245 (32.0%) males, with a mean±standard deviation (SD) age of 19 years 8 months±1 year 4 months (range 18–25 years); 539 (70.5%) were in the age group of 18–21 years and 226 (29.5%) in the age group of 22–25 years. 486 (63.5%) were from an urban background; 367 (48.0%) were Christians and 398 (52.0%) were non-Christians (Muslim-42 (5.4%); Hindu-356 (46.5%).

Conscientious objections towards abortion

Of the 765 participants, 691 (90.3%) had no objection towards abortion while 74 (9.7%) had CO and there was a statistical significance (p=0.000) between the two groups. Of those who had no objection, 464 (67%) were females and 227 (33%) were males; 18 (24.3%) males and 56 (75.7%) females had CO towards abortions.

There was a greater acceptance to abortion irrespective of the gender. The only exception was seen among females to abortion on demand beyond 20 weeks. More men had no objections to abortions (Table 1).

Irrespective of place of residence, medical students were more likely to have no objection to abortion, except beyond 20 weeks (Table 2).

Religion and abortion

A statistically significant difference ($p<0.05$) existed between the opinion of non-Christians and Christians, former were likely to have no objections towards abortion. Only in case of congenital abnormalities <20 weeks (60%), raped minor, (<20 weeks, 74%; beyond 20 weeks, 61%) Christian students agreed for abortion (Table 3).

Referral of patients in case of conscientious objections

Among students who objected to conducting an abortion themselves, irrespective of religion, majority had no issues with referring the woman to another doctor who would carry out the procedure (Table 4).

Table 1: Views on abortion based on gender.

Parameters	Objections to abortions N (%)	No objection to abortion N (%)	X^2	P value
<12 weeks				
Female	227 (43.7)	293 (56.3)	12.623	0.000
Male	74 (30.2)	171 (69.8)		
Beyond 20 weeks				
Female	285 (54.8)	235 (45.2)	7.670	0.004
Male	108 (44.1)	137 (55.9)		
Congenital abnormalities <20 weeks				
Female	148 (28.5)	372 (71.5)	1.065	0.172
Male	61 (24.9)	184 (75.1)		
Congenital abnormalities beyond 20 weeks				
Female	241 (46.3)	279 (53.7)	4.762	0.17
Male	93 (38.0)	152 (62.0)		
Failed contraception <20 weeks				
Female	241 (46.3)	279 (53.7)	7.388	0.004
Male	88 (35.9)	157 (64.1)		
Raped minor <20 weeks				
Female	94 (18.1)	426 (81.9)	1.039	1.80
Male	37 (15.1)	208 (84.9)		
Raped minor beyond 20 weeks				
Female	171 (32.9)	349 (67.1)	3.152	0.045
Male	65 (26.5)	180 (73.5)		

*Statistically significant.

Table 2: Views on abortion based on place of residence.

Parameters	Objections to abortions N (%)	No objection to abortion N (%)	X^2	P value
<12 weeks				
Urban	190 (39.1)	296 (60.9)	0.035	0.455
Rural	111 (39.8)	168 (60.2)		
Beyond 20 weeks				
Urban	246 (50.6)	240 (49.4)	0.304	0.317
Rural	147 (52.7)	132 (47.3)		
Congenital abnormalities <20 weeks				
Urban	138 (28.4)	348 (71.6)	0.775	0.213
Rural	71 (25.4)	208 (74.6)		
Congenital abnormalities beyond 20 weeks				
Urban	215 (44.2)	271 (55.8)	0.181	0.363
Rural	119 (42.7)	160 (57.3)		
Failed contraception <20 weeks				
Urban	203 (41.8)	283 (58.2)	0.832	0.201
Rural	126 (45.2)	153 (54.8)		
Raped minor <20 weeks				
Urban	78 (16.0)	408 (84.0)	1.085	0.173
Rural	53 (19.0)	226 (81.0)		
Raped minor beyond 20 weeks				
Urban	141 (29.0)	345 (71.0)	2.109	0.086
Rural	95 (34.1)	184 (65.9)		

Table 3: Objections to abortions among Christians and non-Christians.

Parameters	Objections to abortions (%) N (%)	No objection to abortion (%) N (%)	X^2	P value
<12 weeks				
Christian	208 (56.7)	159 (43.3)	88.766	0.000
Non-Christian	93 (23.4)	305 (76.6)		
Beyond 20 weeks				
Christian	249 (67.8)	118 (32.2)	76.644	0.000
Non-Christian	144 (36.2)	254 (63.8)		
Congenital abnormalities <20 weeks				
Christian	146 (39.8)	221 (60.2)	55.170	0.000
Non-Christian	63 (15.8)	335 (84.2)		
Congenital abnormalities beyond 20 weeks				
Christian	211 (57.5)	156 (42.5)	58.476	0.000
Non-Christian	123 (30.9)	275 (69.1)		
Failed contraception <20 weeks				
Christian	213 (58.0)	154 (42.0)	65.027	0.000
Non-Christian	116 (29.1)	282 (70.9)		
Raped minor <20 weeks				
Christian	96 (26.2)	271 (73.8)	40.565	0.000
Non-Christian	35 (8.8)	363 (91.2)		
Raped minor beyond 20 weeks				
Christian	142 (38.7)	225 (61.3)	20.338	0.000
Non-Christian	94 (23.6)	304 (76.4)		

Table 4: Referral of patients among medical students who object to abortion.

Conditions and gestational age (weeks)	Would refer the patient (%)		X^2	P value
	Christian N (%)	Non-Christian N (%)		
<12	44 (24.7)	134 (75.3)	0.506	0.276
Beyond 20	69 (29)	169 (71)	0.184	0.107
Congenital abnormalities <20	27 (21.8)	97 (78.2)	0.254	0.138
Congenital abnormalities beyond 20	61 (31.8)	131 (68.2)	0.482	0.249
Failed contraception <20	55 (28.9)	135 (71.1)	1.000	0.505
Raped minor <20	10 (14.7)	58 (85.3)	0.089	0.064
Raped minor beyond 20	47 (34.8)	88 (65.2)	0.890	0.483

DISCUSSION

There is a growing concern that CO should be allowed in clinical practice, legally accommodated, at the same time few are arguing about disallowing CO as it compromises patient's access to health care.[2,5,8,9] There is a large variation in the support for CO (3.5-14.1%) and is high among medical professionals (34.2%).[10] In countries where CO is allowed legally, a high percentage of medical professionals have registered their CO, being high in Portugal (80%), Italy (71%) and less in Hong Kong (14%).[11] The impact of CO is evident in places with limited access to health services and abortion services, leaving limited options for the women, which may delay, resort to illegal methods or left with no other choice but to continue the pregnancy. This is in denial to the right of safe health of a woman. Few physicians though support patient's decision and right, but refuse to perform abortion. Various aspects of CO are extensively debated in the western countries, while it is less explored in developing countries.

In India, abortion is governed by the MTP act 1971, which stipulates that pregnancy of <12 weeks may be terminated by a single doctor and for 12-20 weeks pregnancy abortion requires an agreement by two doctors (ICMA, 2016). Abortion is prohibited beyond 20 weeks. Abortion is carried out by a doctor who is trained in the particular procedure and can only be carried out in institutions with license from the government, should a doctor refuses to carry out an abortion, irrespective of the reason, it is generally accepted that the doctor will ensure that the patient is directed to a physician who will carry out the procedure.

In India, termination of pregnancy <20 weeks of gestation age is legal; with MTP amendment bill proposing to extend

to 24 weeks from existing 20 weeks to help rape survivor, and under few justified circumstances up to 27 weeks of gestation age, but requires court order for termination of pregnancy beyond the specified period of gestation. The amendment bill was approved by the Indian Parliament on 29 January 2020. Though abortion was legalized in 1971, 78% were performed outside the healthcare facility and death due to unsafe abortions is high (10-13%) in India.[12] Yokoe et al, report that of 67.1% unsafe abortions 0.3% resulted in maternal death.[13] Treating physician's CO may further worsen this situation.

A survey-based study from India has shown that 55.5% obstetricians do not provide their services to conduct abortion in the second trimester, teenagers and 68.3% are willing to refer these patients.[14] Acceptance to conduct abortion was low globally as indicated by Stulberg et al which was 14% but was comparatively high young female physicians (18.6%) compared to males (10.6%).[15] It is much lower in Poland with only 8% willing to perform termination of pregnancy, though 65% physicians who participated in the study supported patient's decision and only one obstetrician was against the decision.[16] A Finnish study has found that clinical indications such as criminally conceived pregnancy (2.5%-8.7%) and medical emergencies, social reasons (18.3-22.7%) influence the application of CO to terminate pregnancy.[10]

CO is prevalent among medical students. In United Kingdom, where CO is denied, medical students have expressed their support to physician's right to CO for any procedure (45.2%), but a higher proportion of them did not have objection to perform medical procedures and there was no gender difference. Males and those from the Muslim community expressed their CO.[17] In Norway, 27.3% surveyed medical students supported physician's right to exercise the right to CO.[18] A survey-based study revealed that undergraduate medical students from Spain indicated that a greater proportion of students support patient's decision to abort and CO has negative impact on the patient's health (70%), hence, prefer not to reveal their CO (70.8%). However, there was a clear indication for the support of CO among physicians (72.9%).[19] Majority of trainees (95.9%) from New Zealand were supportive of availability of healthcare services for safe abortion and training in their course to conduct abortion (>68%).[20]

Green in 1993 reported that in cases with congenital malformations, Down's syndrome, obstetricians were willing to terminate the pregnancy, but within 24 weeks of gestation; there was a drastic dip in the percentage of those who would do abortion after 24 weeks.[21] The same mood was reflected even in 2001; majority of the obstetricians preferring to terminate, if pregnancy is <13 weeks, very few expressed their no objection for termination at 24 weeks, and the support for extending it to 24 weeks was not sufficient. Few participants were negative about the termination beyond 24 weeks even for those with congenital anomalies that are incompatible with life but the support for the same for dwarfism for high (75%).[22]

In our study, there was a female preponderance (68%) among the respondents, majority were in the age group of 18-21 years (70.5%). Acceptance rate was high among our participants (60.7%) and among females; this can be attributed to higher percentage of females in the study but on individual parameters studies, men had less objection. It is possible that female participants could relate to themselves, hence, expressing concern by objecting. Objection was less for congenital abnormalities (27%), failed contraceptive measure (41.1%), raped minors (16.6%). Objection (~50%) was noted against voluntary termination of pregnancy beyond 20 weeks.

In our study, rural or urban background did not have any influence on the opinion of medical students on abortion as greater proportion of participants had no objection. Lesser proportion of those from rural area (65.9% versus urban 71%) had no objection in case of pregnancy beyond 20 weeks in raped minors, though the difference is statistically not significant (p=0.086).

Influence of religious and moral reasons

The influence of religion on perception of reproductive health and abortion is marked among the medical students; religiosity and frequency of visit to places of worship shaped individual's approach towards abortion. Considerably high proportion (25%) of medical students are reluctant to refer the patient.[23] Belief in followers of Christianity was one of the reasons for refusal to perform abortion.

There was a clear indication of strong influence of religion on the students 'opinion in our study with a higher proportion of Christians (68%) having objections towards abortion. This is higher than the objection (57%-60%) seen in a study in Norwegian students that assessed if religion played a significant role in medics clinical decisions relating sensitive issues that confronted with their religious beliefs such as abortion, euthanesia.[24] In our study, conditions such as congenital abnormalities <20 weeks (60%), raped minor, (<20 weeks, 74%; beyond 20 weeks, 61%) Christian students agreed for abortion. While various denominations of Christians were not collected, Christianity has been consistently pro-life, which explains the pattern noted in the study.[25]

We noted that objection was more when pregnancy exceeds 20 weeks; this could be due to the awareness among the students about the complications associated with late termination. This may be also be attributable to the common religious belief that by 20 weeks, the fetus gains a life/soul.

Referral

Students in the West preferred to refer if they had CO and is high (95%) compared to our study (60.8%) and had no issues with referring the woman to a competent colleague to carry out the procedure indicating their concern for the

woman's right to safe health.[26] In our study, though the objection was more from the students from the Christian community, those who would refer women seeking abortion to a colleague were non-Christians. In case of raped minor with <20 weeks of gestation those who had CO, only 14.7% of Christian students preferred to refer; 85.3% of non-Christian students preferred not to refer in case of raped minor <20 weeks, which went down to 65.2% beyond 20 weeks.

During the training period, residency, medical students must be taught to make the choice judicially without compromising patient's safety and by adhering to Institution's policy on CO. they must be made aware that by exercising CO, they are violating the commitment as a physician. They must make patients aware about their CO and refer to a competent colleague who does not have CO. Besides, their refusal adds to the work burden of other colleagues.

CO to abortion is a two-edged sword, affecting the health of the woman seeking medical assistance if physician adheres, and belief and psych of the physician if not adhered to. As medical students chose their profession, the role for CO must be limited while exercising their duties and clear guidelines required for excluding situations for CO.

Physician may have a right to reject to assist patients in repeated voluntary abortions, but do not have much choice in case of malformation or maternal complications arising due to pregnancy. All possible measures to minimize, reduce or remove the interference of CO in clinical practice must be encouraged.

This study only assessed at the attitude and not the actual practice of the respondents. Would these attitudes change as students advance in their professional endeavors, needs further studies in our students for an answer that may help to decide if CO to be allowed in our clinical settings. It is crucial to chart out the clinical scenarios where CO may be allowed without jeopardizing the health of the woman seeking medical assistance. While this study does throw some light on conscientious objections in medicine, particularly towards abortion, questions still remain regarding if it to be ethically permitted, the deciding factors, clinical conditions that exempt CO and the authority to decide. There is a need for national guideline, adequate orientation in guiding the medical students regarding CO in clinical practice, without jeopardizing patient's right for safe health.

CONCLUSION

CO is prevalent among the Indian medical students, but many consider woman's right to safe health and refer them to a competent colleague. Though the CO is towards voluntary termination of pregnancy, pregnancy beyond 20 weeks, medical students were considerate towards rape victims. Religion plays a significant influential role in shaping the beliefs.

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