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MEDICAL EDUCATION

Fostering Discussion When Teaching Abortion and Other Morally and Spiritually Charged Topics

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Abstract

Best practices for teaching morally and spiritually charged topics, such as abortion, to those early in their medical training are elusive at best, especially in our current political climate. Here we advocate that our duty as educators requires that we explore these topics in a supportive environment. In particular, we must model respectful discourse for our learners in these difficult areas.

How to Approach Difficult Conversations

When working with learners early in their medical training, educators can find that best practices for discussion of morally and spiritually charged topics are elusive. In this article, we address how to meaningfully discuss and explore students' conscientious objection to participation in a particular procedure. In particular, we consider the following questions: When, if ever, is it justifiable to define a good outcome of such teaching as changing students' minds about their health practice beliefs, and when, if ever, is it appropriate to illuminate the negative impacts their health practice beliefs can have on patients?

These questions emerge for educators in obstetrics and gynecology most frequently with the topic of abortion. While we will focus our essay squarely on discussing abortion, it should be noted from the outset that our approach to this difficult topic can also apply to teaching other topics on which disagreement and divergent views persist. Our goal is to encourage all educators to create supportive space for open discussions on these topics.

Listen

First and foremost, our approach involves listening carefully so as to show respect for the views presented. Our students' beliefs, like our own, have developed over a great deal of time and are influenced by their unique experiences, their families, where they grew up, and so on. These beliefs are deeply held, can be defined as identity constituting, and require our respect and attention.

Showing respect involves not only careful listening but also ensuring that the student is given a safe environment in which to discuss ideas. Such discussions should typically not be held on rounds, as these are generally conducted in open spaces in hospital clinical care areas. If students (presumably a minority) are bold enough to share their views on rounds, they should be supported in speaking out and then later asked if time can be set aside in a neutral space to discuss their views further. Should students decline, of course, that is their prerogative. Our experience is that when offered the opportunity to discuss views on these difficult topics, students have welcomed it.

Similarly, all students present should be afforded a similar opportunity to discuss their points of view, assuming the views were shared in a group setting—which is rare. Group discussions of difficult topics can be fruitful but only with assurances ahead of time from all who wish to participate that they will engage with each other respectfully and without any specific goal except to hear and exchange views on the topic. Our experience is that difficult topics are typically raised by individuals and not in a group setting, which is indicative of students' desire to explore difficult topics in a safe environment.

Commit to an Open Discussion and Create a Supportive Environment

Assuming we have listened carefully and patiently, we can then reasonably request that our students also listen to our opinions and values on the topic at hand, informed by lengthy experience in practice. We talk about our years of experience not to set ourselves apart from or ahead of our learners but instead to emphasize and share that our own views have changed over time as we have experienced more of life and more of the practice of medicine. Students should understand that medical school and residency will almost surely change their views of many things—even if not the issue at hand. Keeping an open mind is essential to becoming an excellent well-rounded physician. To answer one of the questions posed earlier, we typically make clear that our goal is not to change students' minds but to ask instead that students remain always open to new perspectives, as we do ourselves.

The alternative would be to actively seek to change the minds of our learners on the topic of abortion (or another difficult topic). Given that there remains reasonable and active debate about the ethical permissibility of abortion, it would not be respectful for us as educators in a position of power to confront our students in this way. Certainly, we can present our point of view and how we've arrived at it; yet, we must at all times remain open to hearing our students' points of view. Our experience has shown us that the most successful approach is a mutual exploration of ideas and the literature surrounding them.

Thus, we find we must be open to discussion of all facets of the debate. We encourage our students to openly share what they have read on the topic along with any and all ideas that have come to them over time. There is nothing "off limits." We can commit to

each other that we believe each has the best of intentions in the discussion and in our work. In this way, our conversation can be wide ranging and hopefully without judgment.

As noted above, a wide-ranging discussion can't ensue on the wards or in the midst of a busy clinic. Instead, a neutral time and place can and should be set to fully explore the topic. We've found that most students who do not share our views on the topic of abortion—or any difficult topic—welcome the opportunity when offered to have an open conversation. Especially for those with viewpoints on one or the other extreme of the debate, it is rare to be able to safely explore counterpoints. Such conversations are essential for all of us in medicine. As educators, we must foster these conversations and thereby model a respectful mode of discourse.

Discussion Specific to Abortion

We can't cover in this short essay all the myriad points that can be explored in a discussion of the ethics of abortion or even conscientious refusal to learn to provide abortion care. Being willing to pull papers and compare our reads of various "debates within the debate" has been the source of rich and lengthy discussions with our students. Here, we can only briefly explore some key points that frequently arise and hope by that to encourage these types of discussion.

At the outset of conversations with those who conscientiously object to learning to provide abortion care, we typically acknowledge that asking anyone to perform an act they see as murder would be wrong, and thus we support a student's decision to refuse to participate. We likely also would fairly quickly agree to disagree about when "life begins" or when an embryo can be deemed to have moral status precluding provision of abortion services. This is not to say that this point does not merit an incredibly complex discussion, and we happily explore it with students. Yet, given a difference of opinion on this point, there is rarely a piece of evidence that would convince either of us to "come to the other side." Agreeing to disagree on this point is, in fact, helpful both for us and for students. Reaching an understanding that we can disagree on such a fundamental point—given that no dispositive evidence exists—yet still respect each other's points of view is an important step.

The bulk of our discussion then seems to focus on what a student's decision to conscientiously object to learning to provide abortion care will mean for their patients and for how they will care for them. We also discuss what it will mean for the broader community where they practice and for other clinicians who work with them or near them. For each student, depending on his or her intended medical specialty and practice setting—urban or rural—the answers to these questions will be very different. We remind our students that "health care providers with moral objections to providing specific services have an [equally important professional and moral] obligation to minimize disruption in delivery of care and burdens on other providers."[1]

Thus, our answer to the question of whether we can illuminate the negative impact a student's health practice beliefs can have on patients, particularly those with limited options, is a resounding yes. In fact, this is our duty as educators. In making any health care decision that will close the door to a certain option for a patient, we as "gatekeepers" must explore what closing that door will mean to the individual before us and to the broader community where we practice.

Our students who conscientiously object to providing abortion services must take into account all that comes before and after their refusal to provide abortion services for their patients. This discussion of the patient's needs can be fairly wide reaching and might encompass discussions of religion, history, and the law. Yet, primarily the focus is on lack of access to care, education, and services. We hope to put context into the discussion by exploring the patient's possible lack of access to preventative care, sex education, contraceptives, support services during pregnancy, support for young children, and subsidized childcare and by exploring recent trends in increasing maternal mortality.[2] This exploration of context might involve telling the stories of patients we've met over the years or reading papers about the current lack of access to care and what that means in terms of obstetrical outcomes and the general health of women in our country. Understanding the downstream and collateral impact of decisions we make as physicians is not something that we fully grasp upon admission to medical school. It is learned over time. As medical educators, bringing perspective to our discussions with learners is not limited merely to sensitive or charged subjects.

Again, we do not seek to change our students' opinions in exploring abortion or any difficult topic. Instead, we recognize that all the students we have encountered who conscientiously object to the provision of abortion services do so out a deep sense of care and responsibility. We know that this same commitment extends to their patients, so we must ensure that they fully understand the import of their refusal, just as they must fully understand the import of any action (or inaction) they take in medicine. Thus, we carefully explore what students feel is their responsibility to patients with respect to all these issues. If they are going to limit access to abortion services through their choice of specialty and conscientious refusal, then they must decide whether it is their duty to ensure that women have access to preventative care, contraceptives, family planning services, parental leave, and child care. Similarly, we explore the topic of referral and after care.

Given that we are engaged in a discussion, we do not tell our students what they must or must not do. That is not our purpose. We engage in advocacy in other arenas. Instead, we discuss with our students how all our patients, even those with whom we disagree, deserve our respect and care. This commitment will at times mean that we must refrain from burdening our patients with our own uncertainty or, potentially, with delays in care

should our decisions as physicians be difficult. We can't say definitively what this will mean for each student. It will depend on multiple factors related, as previously stated, to their choice of specialty and location of practice. Our hope is that they think not only of the issues related to the procedure itself but also of all the downstream effects on their patients and the community in which they practice.

Frequently, our conversation will stall a bit here. We typically do not reach a definitive answer during our first conversation. We always circle back to our deep respect for our students' views and our belief that our students should have the ability to refuse to participate in a procedure they find inherently immoral while still being a valued member of the medical profession. We always leave the door wide open to further conversations, and typically our students take us up on this offer.

By engaging our students in this way—by listening and creating a supportive environment for open discussion—we hope, ultimately, if nothing else, to foster a culture of respectful discourse essential to higher learning.

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