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Views of healthcare professionals dealing with legal termination of pregnancy up to 12 WA in French-speaking Switzerland

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Summary

BACKGROUND: In 2002, by popular vote, Swiss citizens accepted to legalise termination of pregnancy (TOP), up to the 12th week of amenorrhoea (WA). As a result, the cantons formulated rules of application. In 2002, medical TOP was authorised. Health institutions then had to modify their procedures and practices.

QUESTIONS UNDER STUDY/PRINCIPLES: What are the views of healthcare professionals on the modifications of procedures and practices implemented in French-speaking Switzerland?

METHODS: Qualitative method: in-depth interviews with 77 healthcare professionals, including doctors, nurses and midwives, and sexual and reproductive health social workers. Voluntary participation. Thematic analysis with content analysis software.

RESULTS: Most professionals have a balanced point of view on their practices. There is no point of view specific to each different category of professionals interviewed. They are unanimous on the elimination of the need for a second opinion. The points of view diverge on the usefulness of imposed waiting time to think before TOP, minors' access to TOP without parental consent, access to medical TOP and the right to refuse to practice TOP for personal reasons in public hospitals.

CONCLUSIONS: The professionals do not question women's right to have TOP up to 12 WA, but they do diverge over procedures and practices. Institutional and cantonal cultures are probably behind these differences.

Key words: law reform; termination of pregnancy; women's clinical courses; gynaecologists; healthcare professionals; medical abortion; conscientious refusal

Introduction

In June 2002, Swiss citizens voted by a 72% majority to accept new laws in the Criminal Code (Articles 119-120) which legalised the termination of pregnancy (TOP) up to 12 weeks of amenorrhoea (WA), as is the case in 22 other European countries [1].

Compared to the previous situation, the main modifications introduced by the legalisation of TOP are the following: the decision belongs to the woman who signs a TOP request. She no longer has to consult two physicians (elimination of second medical opinion). The doctor must ensure her consent. The time limit is set at 12 WA. The woman receives and signs an official informational document. Women under age 16 must visit a specialised consultation centre for minors. Following the passing of this law, the case-course of women requesting a TOP is supposed to be simpler.

Following this vote, each canton had to devise rules of implementation. Public hospitals now had the obligation to ensure women's access to TOP, and had to adapt their practices to this law, as did private clinics and doctors who wished to perform TOP in their office.

During the 2000's, other important changes came into play: the commercialisation of the emergency contraception pills; the introduction of a medical TOP method (Mifégyne, RU486); the reorganisation of public hospitals.

In an article presenting the first part of our study, centred on rules of implementation and women's clinical courses (Perrin et al. [2]), we noted large differences between these new legal norms and women's real courses, concerning the number of days to wait between the women's decision and TOP, the number of appointments attended before TOP, the method of TOP, and the cost of TOP. In this first study, the only significant statistical variable was the size of the institutions.

However, it seemed unlikely to us that this variable alone could explain the differences we observed. We supposed that the healthcare professionals responsible for imple-

menting such changes played an important role as well. This second qualitative study is centred on their points of view. This material allowed us to go a step further in the analysis, as have shown other studies in this domain [3–5] as well as one [6] out of our previous studies [7–11]. Studies concerning the viewpoints of professionals who practice TOP are rarer than those devoted to women who have undergone TOP. Swedish studies have focused on gynaecologists and midwives confronted with TOP (Hammarstedt et al. [3–4]; Lindström et al. [5]). Others have focused on the introduction of medical TOP in the 2000's in Europe and in the U.S.A. (Jones et al. [12]; Boonstra [13]; Joffe et al. [14]; Grimes et al. [15]), or on the importance of the political context on practices (Fielding et al. [16]). The studies by Lowenstein et al. [17] and by Ashok et al. [18] comparing the psychological distress brought on by the two different methods of TOP underline the importance of giving women their choice of methods. The study by Fiala et al. [19] shows the importance of allowing women the choice of having their medical TOP at hospital or at home. Dennis et al. [20] analyse the consequences of laws necessitating parental involvement when minors ask for TOP in the U.S.A. On the ethical side, Sonfield [21], like the E.U. Network of Independent Experts on Fundamental Rights [22], reminds us that one's right to refuse to practice a legal medical act for conscience reasons works in conjunction with one's obligations to patients.

Material and methods

The study protocol was accepted by the Ethics Committee of the Geneva University Hospitals (June 2005), the Intercantonal Ethics Committee of Jura Fribourg Neuchâtel (September 2005), the Valais Cantonal Commission for Medical Ethics (October 2005), and the Ethics Committee for clinical research of the faculty of biology and medicine at the University of Lausanne (Vaud) (November 2005).

The qualitative study by in-depth interviews with healthcare professionals took place between 2005 and 2007. It mostly involved gynaecologists, nurses and midwives in public hospitals, gynaecologists practicing in private offices, and GPs and sexual and reproductive health social workers (SRSW) in Family Planning Centres.

Recruitment was handled by the research team, in agreement with the heads of gynaecology and obstetrics departments in the hospitals and the Family Planning Centres in French-speaking Switzerland. Their participation was voluntary. The inclusion criteria for professionals in this study was to have worked in a service confronted with TOP before and after June 2002, and therefore to be capable of evaluating the evolution of practices before and after legalisation of TOP. We tried to obtain interviews in most of the healthcare institutions in French-speaking Switzerland,

in order to have a large and diverse range of viewpoints, as is common practice in qualitative studies (Pope et al. [23]). The interview revolved around the modification of practices that took place after 2002 in their service, their personal point of view on these changes and the TOP methods. Socio-demographic questions allowed us to situate the responders. The length of interviews varied between 45 minutes and 1 hour 30 minutes.

Seven researchers, specialists in social sciences, led the interviews. They were recorded, transcribed and analysed with the help of the qualitative analysis software QSR NVivo 8. This process of qualitative data analysis corresponds to the customary approach in the health field (Pope et al. [23]).

Results

The following results are based on the analysis of 77 interviews with healthcare professionals. The interviews began in 2005 with the SRSW (N = 15), continued in 2006 (N = 27) and 2007 (N = 35) with the other professionals. They took place in 12 Family Planning Centres, 11 hospitals and medical offices located in 16 cities and towns of the 6 French-speaking cantons. The number of interviews varied depending on the number of institutions (hospitals, Family Planning Centres, private medical offices) in each canton. The nurses (N = 31) and the midwives (N = 4) were grouped in the same category. They represent a bit less than half of the interviewed professionals (N = 35). The doctors, gynaecologists for the majority (N = 19), represent one-third of the interviewed professionals (N = 25). The SRSW represent one-fifth of the interviewed professionals (N = 15), to which is added one social assistant (SA) and one psychologist (N = 2) (table 1).

The majority were women (N = 61). All the men were doctors (N = 16). The age of the interviewed professionals varied between 32 and 71 years of age (average age: 48). Two-thirds were married (N = 51). More than three-quarters had one or more children (N = 61). Three-quarters were of Swiss nationality (N = 59). The others were of French nationality (N = 14) or another nationality (N = 4). Their number of years' professional experience in the TOP field varied between 3 and 34 years (average: 13 years). The majority had practiced for more than 5 years (N = 62). Two-thirds of the interviewed professionals worked in average-sized, non-university hospitals (N = 52), one-third in large, university hospitals (N = 23), and a small minority in private (N = 2). The majority, 4 professionals out of 5, had not changed institution since the beginning of their professional careers (N = 61) (table 2).

Table 1: Distribution of interviews by profession and by canton.

| Professions / Cantons | VD n | GE n | JU n | FR n | NE n | VS n | Total n |
|-------------------------|-----------|-----------|----------|----------|-----------|----------|------------|
| Doctors | 12 | 5 | 2 | 2 | 3 | 1 | 25 |
| Nurses, midwives | 14 | 6 | 3 | 3 | 7 | 2 | 35 |
| SRSW, SA, psychologists | 7 | 3 | – | 2 | 1 | 4 | 17 |
| Total | 33 | 14 | 5 | 7 | 11 | 7 | 77 |

Analysis of interviews

The qualitative analysis of the interviews aims to render the range of expressed viewpoints as faithfully as possible. To do this, we selected excerpts from the interviews that best represent the different dimensions we documented.

The quotes illustrating these different viewpoints are identified by a number assigned at random and by the professional category of the responder: nurse and midwife (NUR) or social worker (SRSW). Only one category allows a gendered identification, that of doctors. A W or an M (WDOC or MDOC) indicates them. To guarantee confidentiality and anonymity, the canton and institution where the responders work are not listed.

Two statements of fact stand out clearly in the analysis of the gathered material. First, most of the healthcare professionals have developed a balanced point of view on TOP and its practices. Clear pro- or anti-TOP stances were rare (5 out of 77). Second, no category of professionals has a specific viewpoint (doctors, nurses or SRSW). Differences of opinion cross all categories of professionals.

Detailed analysis showed multiple viewpoints, which focus around 1) the attitudes regarding the simplification of women's courses, including minors' without parental consent;

2) TOP methods; 3) hospitals' obligation to ensure access to TOP and the conscience clause.

Attitudes regarding the simplification of women's courses, including minors' without parental consent

The elimination of the need for a second opinion constitutes the most visible element of the simplification of women's courses. All the professionals interviewed greeted it with satisfaction.

If everyone agrees that the decision to undergo TOP is a difficult one for women to reach, viewpoints diverge on the question of the length of women's courses. For some, women are ambivalent and they should impose them some thinking time. To accelerate their course would be a mistake.

“So yes, the easiest solution is the supermarket... And that doesn't exist. We can't turn medicine into a supermarket. When one has an appointment, one must ask oneself the question. And then there is a thought process to have about terminating a pregnancy. As we've said, many women are ambivalent, who have a whole reasoning process to work through before calling us. Often they want it to be done immediately, immediately. But it's precisely those women who

Table 2: Study sample characteristics.

| Sex | Responders (n = 77) | (%) |
|--|---------------------|------|
| Men | 16 | 20.8 |
| Women | 61 | 79.2 |
| Age | | |
| 32–35 | 5 | 6.5 |
| 36–45 | 28 | 36.3 |
| 46–55 | 26 | 33.8 |
| 56–65 | 13 | 16.9 |
| 65–71 | 3 | 3.9 |
| Missing response | 2 | 2.6 |
| Civil Status | | |
| Single | 14 | 18.2 |
| Married + living as a couple | 51 | 66.2 |
| Separated, divorced, widowed, other | 12 | 15.6 |
| Children | | |
| None | 16 | 20.8 |
| 1–2 | 37 | 48.0 |
| 3–4 | 24 | 31.2 |
| Nationality | | |
| Swiss | 59 | 76.6 |
| French | 14 | 18.2 |
| Other | 4 | 5.2 |
| Years of Experience | | |
| 3–5 | 10 | 13.0 |
| 6–10 | 23 | 29.9 |
| 11–15 | 17 | 22.1 |
| 16–20 | 13 | 16.9 |
| 21 and + | 9 | 11.7 |
| Missing response | 5 | 6.5 |
| Type of institution | | |
| Large University Hospital | 23 | 29.9 |
| Average-sized, non-university hospital | 52 | 67.5 |
| Private Doctors' Office | 2 | 2.6 |
| Institutions since the beginning of their careers | | |
| Has not changed | 61 | 79.2 |
| Changed | 14 | 18.2 |
| Missing response | 2 | 2.6 |

shouldn't have their termination of pregnancy immediately, because often they're the ones who are the most ambivalent. So...for it to be quicker, I don't think would be a plus." (17 WDOC)

"Even if the woman has thought a lot before coming to ask for TOP, the moment when she comes in is an important step. It's at this moment that she really becomes aware that she is going to do it. So there must be a certain time to wait, several days at least, or even a week, to be able to digest that." (28 NUR)

"There is a psychological suffering which is there, which is present. There is a feeling of guilt. There are many things that mix up, which are there on that day and I think that if someone can listen and take time with these issues, I think that's important." (65 SRSW)

For others, a quicker access to TOP seems normal and salutary. Women are responsible and capable of deciding.

"What do I think of this new law? I think it's very good; that women have the right to abortion is a minimum. [...] I think, I've always thought, that it is in women's capacities to know what they want and then to decide. And if they are not capable, that is obvious when we have a simple consultation with them. Of course we can help them. But for the principle, I think that to put women under guardianship by saying that in any case they are stupid, immature and psychologically suffering, and incapable of knowing what they want, that seems particularly unhealthy." (01 MDOC)

"As for the procedure, they generally come here with a very precise idea. I don't have many, or actually almost none, who have changed their minds." (08 MDOC)

"So as a woman, I do find that now we give the woman responsibility, and that means that the woman doesn't have to explain her whole story." (62 SRSW)

Concerning minors, the viewpoints diverge. Some express themselves as individuals, whereas others speak of an institutional or cantonal decision ("here", "it was postulated").

"For the under 16s, I don't even start with them if the parents are not informed. I don't even start, it's "thank you, good-bye". Whether the family is Albanian or Swiss ..." (25 MDOC)

"Here it was decided that for the under 16s who come in without their parents being informed, despite our recommendation that the girls inform them, that they would have an obligatory visit to a child psychiatrist." (13 WDOC)

"In this canton, it was postulated, rightly or wrongly, that beyond 14 years old, an individual is in principle capable of discernment, and that under 14, not. Yeah, it was chosen like that." (02 MDOC)

The dilemma is legal, economic and ethical all at once. On the one hand, parents are responsible for their children until age 18, the legal majority (whereas sexual majority is set at 16 years old). This is why some even think that the family decides in their place. On the other hand, doctors must respect confidentiality, and are responsible in case of problems. Finally, the health insurance companies don't respect confidentiality, since the minors' consultations are listed on their parents' statements. In order for the secret to be kept, minors have to pay for TOP out of their own pockets. Faced with this dilemma, there is no unanimity.

"You also have to see what type of parents and what kinds of consequences it can bring on. I think and I hope that

social workers encourage most of these young people to speak to their parents ... Unless they risk being stoned to death or being sent back to their village or ... [...] If possible, I think that parents should be informed but I don't know if they always are. I don't think so. Especially since this type of operation can go wrong sometimes, even if it is a medical act ... [...] A 14 year old girl whose parents are not informed, she's a minor, she is not responsible, it's her parents who are responsible for her after all." (04 MDOC)

"The problem, when the parents are not informed, is that we can't make use of the young girl's insurance, and then we find ourselves with financial problems. [...] And as soon as someone is informed, we can send it to the insurance. Because otherwise, it's debts that she'll get." (17 WDOC)

"It is certainly different because they don't have much choice. At age 16, perhaps they don't even realise what is happening to them. There is still a difference in the maturity level. Yeah, it's the family who decides in their place, I imagine that the girls are not the ones making the decision, it's the family." (60 NUR)

"We have the protocol that we must ensure certain things by asking the young girl questions, notably whether the fact that she is pregnant is the result of a forced sexual relation or not. We are always on the lookout to diagnose abuse and things like that." (63 SRSW)

"You have to see because there are some people who are very mature despite their age, and others who are very infantile, so we adapt our behaviour to the specific needs. We do the best we can." (56 NUR)

"For the under 16s, we are held to professional secrecy. We are not going to inform the parents, it's clear, we have very few. We talk with them, often we involve Family Planning." (18 MDOC)

"If she's big enough to come by herself, she has the right to medical secrecy." (06 WDOC)

TOP methods

The two methods practiced in French-speaking Switzerland, surgical TOP with general anaesthesia and medical TOP, have advantages and disadvantages. Medical TOP is at the centre of debates. Many doctors are surprised by the success of this method amongst women.

"I think they come in more and more frequently very early, and it is not because of the law that changed that they come in faster but that they know that the medicine exists. And I'm stunned at the number of times women say: "I would prefer the medicine." (09 MDOC)

They have weighed the advantages and disadvantages of both methods. Their preference will influence their patients' choice and they are conscious of that.

"I give them the choice. I say: "Here's how it happens... You can choose." But after, it's clear that they ask me: "But what do you think?" And then I have to tell them what I think, in fact, because I am rather "surgical"... at least in my mentality. And medical TOP is not so easy because you walk around for several days... You take pills, and especially, during one day, when you get the Cytotec, that gives you contractions, it hurts, you don't know when it will bleed, you don't know if it's complete or incomplete, you

need to be accompanied by someone... It's much heavier psychologically ..." (11 MDOC)

"We explain to them orally the choice between medical TOP and surgical TOP. And then we explain the technical advantages and disadvantages. I do most TOPs by medicine, surely because I am for it ..." (08 MDOC)

"We push towards what we think is the best, which means for me that before 7 weeks, I will always push towards an RU. [...] There's no surgical risk and no anaesthesia risk! We can avoid them in 95% of cases, of course it's better!" (23 WDOC)

"It's good because they're not hospitalised [for the RU]. Those who go to school can do it. If they go to work, they can do it too. [...] And that's an advantage. But after, for the rest, it's not an advantage because you have to come in several times. So on that front there's surely something to be done. There are some doctors who practice this in their offices, who give the medicine, [...] do the follow-up in one, two appointments and that's it. Then the woman calls the doctor herself if she has any complications. So I think we could go further with this idea." (28 NUR)

Some professionals point out that they exclude this method if the woman is indecisive, fearing that she might change her mind between the 1st and 2nd doses of medicine. They also exclude it for foreign or clandestine women, fearing that they won't return for the 2nd dose because they have misunderstood or that they don't have money.

Concerning minors' access to the RU, institutional positions, signified by the use of "we" or "us", are variable.

"Between 16 and 18, there is always the legal problem. Therefore we decided internally that we wouldn't use the medical TOP method for those women. Sometimes now, we make exceptions for different reasons, but they remain exceptions." (13 WDOC)

"In general we suggest that they stay a few hours in the outpatient ward [for the RU]. We noticed that these young girls are very fragile. They couldn't handle the pain at all and they were panicked at the idea of doing it all alone. So we suggested that they be followed by nurses, by a medical team." (18 MDOC)

Public hospitals' obligation to ensure access to TOP and the conscience clause

In the public hospitals, now obligated to ensure access to legal TOP, the question of work organisation is raised when healthcare professionals refuse to do the work, by invoking the conscience clause. Professionals' points of view diverge on what attitude to adopt under these circumstances.

"Ideally, everyone should apply the law and that's it. Because there are always some jokers who consider themselves vested with power, so probably... In certain cantons, it's always the same thing, there are some people who have other vocations than medical vocations, and who consider that they have a moral power in this domain. I feel that we must respect the law that was voted on by a majority of Swiss and that's it. And then to apply it." (10 MDOC)

"What do you think of a public institution in a country where there is a liberalisation of the law like we currently have, what do you think of an assistant who says: 'I don't want to do abortion'? What do you do with that? ...The question is not to oblige him or her to do it, the question

is to keep this person on staff or not? Personally I always refused. Indeed, I pretty much sacked people who didn't want to do it. But that wasn't the exact reason. The reason is that I didn't want to have "blacks and whites". I didn't want to have professionals who regard others like that." (01 MDOC)

"It's been like this for years, if a gynaecologist doesn't do abortion, he or she can't finish his or her medical training. That's not right. Because you will not be hired in a university hospital, or at least not in French-speaking Switzerland, if you don't do them. There you have it. So ethically, we're told that yes [we have the right to invoke the conscience clause] but actually, that's not true." (23 WDOC)

"We have Muslim women assistants who don't really agree with TOP and who sometimes can be very... violent. Exams are not done in the same way with a woman who wants TOP than with a woman who comes in saying 'I'm pregnant and this is my first exam', which in actuality is the same thing: it's a vaginal exam and an ultrasound to see how far along she is. So for a TOP, technically the consultation is the same. And we see this – I see this from the outside and it's perhaps a bit judgmental – but... And I said 'Muslim women' but there are also European women who are against it and who would act in that same way." (57 NUR)

For some, doing TOP is a necessary evil, a morally painful job, and is not well regarded.

"I will never say that abortion should be outlawed because I saw some very difficult cases and I'm not OK with it. Regardless it's hard to do a TOP like that, no matter how, without a real reason. I must say, it shocks me that we have enormous respect for life on one side, and then, all of a sudden if a baby is not wanted, we don't respect it any longer... I still can't understand that. Why this lack of equality? I don't understand... it's personal... In any event, this doesn't come up in our daily lives because we follow the laws." (19 WDOC)

"We're not brainless technicians. I want to say that it's not easy to do an abortion. Who cares about the reasons. [...] I find that we can't say: 'I am for abortion.' It's a necessary evil. But we can't carry the abortion flag, that doesn't make sense. Women must have access to abortion, but for the person who does it, it's a terrible act. /.../ And ethically, doing abortion is not nothing." (23 WDOC)

"I think that if you're a gynaecologist...it must be for everything. It's perhaps the least fulfilling act [doing TOP] but it's still ..." (34 NUR)

Others had a more positive viewpoint.

"I'm for TOP, I do them, OK? I think it's very useful that people have TOP because children resulting from undesired pregnancy, they're social catastrophes, it's the catastrophe of battered children, they're catastrophes after. [...] We live in a prosperous zone because we knew how to manage our fertility. [...] Abortion is a part of a population's fertility management." (14 MDOC)

"I'm absolutely not against [TOP]. Personally I saw abused children, scalded, I saw babies in comas because they weren't wanted. So you know, I think it's better actually, to abort when it's at the state of a comma, than an abused child." (45 NUR)

Discussion

Professionals' viewpoints on the changes brought about after 2002 were not unanimous, aside from the elimination of the need for a second opinion. Otherwise, diverging opinions crisscrossed the group of professionals. Indeed, viewpoints were not specific to each different category of interviewed professionals.

The modes of simplification of women's courses divide the professionals. Some are favourable of introducing a systematic waiting time and/or several appointments before TOP, thinking of women's possible ambivalence. Others think that, barring exceptional cases, this waiting time is not useful, or even iatrogenic, and increases stress and feelings of guilt. The majority of women had already made their decision at their first contact with the healthcare professional. On this subject, an American study evaluated that the percentage of undecided women at their first appointment is 7%, maximum [24]. And as one responder said, women rarely change their minds. Since medical TOP is only practiced until 7 WA (or 9 WA according to the hospital), any waiting time risks eliminating the possibility of choice between the TOP methods.

Requests for TOP by minors who have not informed their parents are unacceptable for some, while tolerated by others. A literature review of American studies led between 1983 and 2008 on the impact of laws demanding parental involvement during minors' abortions [20] notes that the principle impact is the increase of minors' travelling towards states that don't require this condition in order to obtain a TOP. When taking this travelling into consideration, abortion rates and short-term impact on pregnancy rates remained unchanged. This review showed that the situation was the same for minors as was the case for all women before the legalisation of TOP, meaning a search outside their borders to find a place to get it, if possible in safe conditions.

In the process of implementation of the new legal norms, the cantons that were once considered "liberal" had changed very little, while some cantons considered as "restrictive" had made rather large changes (starting from the legal basis of the women's right to have TOP up to 12 WA and the suppression of the need of a second opinion). Some cantons or institutions introduced or kept other hurdles, in the form of unwritten rules, such as imposed waiting time before final decision or denied minors' access to TOP without parental consent, which are not mentioned in the new legal norms.

The acceptance of medical TOP surprised most of the healthcare professionals. Women who make appointments earlier and earlier requested this method more and more frequently. A Swedish team followed the evolution in gynaecologists' and midwives' attitudes over thirty years (1975–2006), and confirmed this evolution [4]. A study on midwives showed that two-thirds of them were happy about the slipping rates of surgical TOP towards medical TOP, and that a majority of them considered that in the foreseeable future it should be managed by primary healthcare [5].

American articles showed that this method now allows a large range of doctors (GPs, internists, paediatricians)

to prescribe the RU 486 [14–15]. A Swedish study [19] showed that 96 women out of 100 having chosen an at home medical TOP were satisfied. The conditions of this success were the following: to have the choice of hospital or home; to have received qualified counselling; to have access to a 24-hour hotline (used by 20% of women); to have painkillers available. Their conclusion was that women are capable of making the right choice by themselves. An Israeli study [17] showing that women who chose medical TOP were afraid of surgical TOP and feared for their future fertility confirmed this. A British study [18] comparing psychological scars from the two TOP methods used between 10 WA and 13 WA showed that there was not an important difference and that women should have their choice.

Another interesting result of our study, regarding the possibility of choice of TOP methods, is that many gynaecologists were aware of their influence over their patients. Even though they are free to choose, women tend to opt for the method that the doctor considers the least risky for them. These points of view were probably developed within healthcare institutions and cantonal cultures, which would explain why in 2006–07, the rate of medical TOP varied between 40% and 90%, depending on the French-speaking canton [25].

In the same line, four participants of our study out of five worked in the same hospital since the beginning of their careers; besides, more than half of the doctors were aged 50 or over, had at least 11 years of professional experience, and had held hierarchical positions in their services for a long time. These characteristics of the professionals volunteering to participate in the study, added to the criteria that they had done TOPs before 2002 in order to be included, introduced a bias, which constitutes a limit to our study. This also led our sample to be more homogeneous than expected. In the quantitative part of our study on women's courses having had TOP [2], only the size of the healthcare institution allowed to explain the differences in these courses. We had supposed that the healthcare professionals, whose job was to implement the new legal norms, had also played an important role and that there were probably institutional and cantonal "corporate cultures". This unexpected recruitment bias allowed us to confirm this hypothesis. Clearly, medical doctors holding hierarchical positions in their services play a major role in the changes of procedures and practices. Institutional and cantonal "cultures" do indeed exist, by ways of procedures and practices as well as by unwritten laws known by everyone in the wards. Some quotes make direct reference to them. For example, some hospitals allow the sexual and reproductive health, social workers to contact the women in the gynaecological ward while others deny them access to the ward. In the same line, in some cantons, women are requested to see the gynaecologist twice, with a few days of delay, before getting another appointment for the TOP, thus possibly preventing access to medical TOP and partially accounting for the wide variation of this method between the cantons. These institutional and cantonal "corporate cultures" also allow an understanding of the differences in the women's courses.

The problems raised by the right to refuse to practice TOP (conscience clause) affect the organisation of labour in the

gynaecology departments of public hospitals: can one accept that, in a team, some professionals refuse to practice TOP, knowing full well that others will have to do them? They also affect medical training: can one become a gynaecologist without having done TOPs? Swedish researchers led several interesting studies on midwives' and gynaecologists' viewpoints on this subject [3–5]. In 1975, Sweden adopted a law very close to the one adopted by Switzerland. Despite a longer legal time limit in Sweden (18 WA) than in Switzerland, 93% of TOPs were done before 12 WA [3]. A representative study with gynaecologists showed that half thought they should have the right to refuse practicing TOP for personal reasons. Their viewpoint was identical concerning midwives. Simultaneously, 87% felt that to perform TOP should be part of a gynaecologist's job and 62%, a midwife's job [4]. A study with midwives showed that 80% considered TOP as being part of their job, and more than half thought that neither gynaecologists nor midwives should have the right to refuse to perform them [5]. As in our study, these results show the typical contradictions in our societies, founded on the respect for freedom of opinion and beliefs, on the principle of equality of treatment at work and on the requirement to put laws into practice. The E.U. Network of Independent Experts on Fundamental Rights [22] and Sonfield [21] underline that if the right to refuse exists, it works in conjunction with an obligation to the patient: to be transparent by announcing it clearly; to allow her to avoid unnecessary appointments; to direct her to a doctor or a nearby institution that performs TOP in safe conditions.

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