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Clinical Cases

Reproductive Rights

Physicians have an ethical duty to provide safe and effective care to patients even when the care conflicts with their own personal values.

Commentary by Watson A. Bowes Jr., MD, Karen E. Adams, MD, and Martin T. Donohoe, MD

Dr. Richard Ward is the only family practitioner in a small rural town where he has been practicing for 30 years. One morning 16-year-old Theresa Scholtz comes to Dr. Richard Ward's office alone. She does not have an appointment and tells the receptionist she will wait until Dr. Ward has time to see her. Dr. Ward has quite a few scheduled appointments that morning, so Theresa has to wait more than an hour before she can be seen.

The nurse finally takes Theresa back to an examination room, weighs her, takes her temperature and blood pressure and then asks the reason for her visit. Theresa looks nervous and ill at ease; she doesn't immediately answer.

Theresa doesn't look at the nurse but says quietly, "I am afraid I might be pregnant."

"So you are here to get a pregnancy test?" the nurse asks.

Theresa shakes her head, "No, I want Dr. Ward to give me the morning-after pill so I don't have to get a pregnancy test or have an abortion."

The nurse gets ready to leave, saying, "Dr. Ward will be in shortly."

When Dr. Ward comes into the exam room Theresa explains to him that she was out at a party, had a few too many drinks, and ended up having unprotected sex with her boyfriend. She says she is worried about the possibility of being pregnant and wants the Plan B® pill.

"I don't want to have a baby right now. I'm too young. I have to finish school," she says. "And I don't want to have to make a decision about an abortion. I want to just take this pill and move on."

Dr. Ward listens to Theresa's concerns and then says, "I understand why you are here. I have always had a policy of not performing abortions, and I won't start now by prescribing the morning-after pill. You can make an appointment with me in a couple of weeks for a pregnancy test to find out if you are pregnant. If you really want the morning-after pill I can give you the card of a physician I know in Gardendale who will see you."

"Gardendale?" Theresa says. "But Gardendale is 115 miles away. How will I get there without telling my parents why I am going? And how will I get there soon enough for the pill to work?"

Commentary 1

by Watson A. Bowes Jr, MD

The most obvious, although not the only, ethical issue in this situation is the conflict between the principle of patient autonomy and the health care provider's right of conscience. Personal autonomy is one of the cardinal principles of modern medical ethics. It implies personal rule of the self that is free both from controlling interference by others and

from personal limitations that prevent meaningful choice. Respect for patient autonomy, like all ethical principles, cannot be regarded as absolute and may at times be in conflict with other principles or other moral considerations. In this case such a conflict arises because the physician, Dr. Ward, is asked to provide care which he regards as potentially equivalent to performing an abortion—by prescribing Plan B®. It is generally accepted that a patient's right of autonomy does not trump the physician's parallel right to conscientiously abstain from a practice on religious or moral grounds provided that (1) the physician provides the patient information that would allow her to seek care with another health care provider who does not have such reservations and (2) the physician's refusal to treat does not endanger the patient's life or result in serious harm.

A meaningful resolution of ethical issues depends to a great extent on accurate clinical facts. Apparently, Dr. Ward knows that the effectiveness and probable mechanism of action of post-coital levonorgestrel 0.75 mg x 2, 12 hours apart (Plan B®) used for post-coital birth control depends upon the time the medication is taken in relationship to the time of ovulation. If taken before ovulation occurs, the effect is temporary delay of ovulation and interference with sperm penetration of the cervical mucous. If taken after fertilization has occurred, the effect might be prevention of implantation of a fertilized ovum, which is the basis for Dr. Ward's refusal to provide this medication. Evidence suggests that the effect on ovulation and on sperm penetration of ova are the predominant mechanisms of action. We are not told when, in relationship to the office visit, Theresa had unprotected sex with her boyfriend, nor is information given about Theresa's menstrual cycle, facts that might provide Dr. Ward a basis for modifying his advice to Theresa. For any particular patient, however, it is difficult to ensure that the medication is being given before fertilization has occurred.

Evidence also indicates that post-coital steroids, by reducing the risk of conception, actually decrease the incidence of induced abortion of clinically apparent pregnancies. Therefore, a physician who opposes abortion for religious or moral reasons must decide whether the use of a medication that occasionally prevents the implantation of a fertilized ovum but decreases the number of abortions overall is an acceptable moral and ethical tradeoff.

Ideally, Theresa's decision to use Plan B® should be made after she has received as much information about the drug as she is capable of understanding. Most importantly, she should understand that post-coital steroids are not 100 percent effective in preventing pregnancy, regardless of when the medication is taken. Even if Dr. Ward were to prescribe the medication, a follow-up visit might be necessary if there were subsequent symptoms or signs of an ongoing pregnancy.

Another important ethical issue is to what extent Dr. Ward's conscientious objection to providing Plan B® for Theresa should be affected by the distance she must travel (115 miles) to reach the nearest physician who will prescribe the medication. And what of Theresa's claim to have no transportation unless she informs her parents, which she does not want to do?

Importantly, Dr. Ward's refusal to provide the prescription for Plan B® is not a threat to Theresa's life. Furthermore, Dr. Ward has offered to provide follow-up, and he would, presumably, be willing to refer her to a colleague if pregnancy were diagnosed. A physician's ethical responsibilities do not extend to solving all social and domestic difficulties of every patient. In other words, short of a life-threatening emergency, he is not obliged to drive her to Gardendale. It is, nevertheless, Dr. Ward's responsibility to advise Theresa about reasonable options, such as confiding in her parents or enlisting the aid of her boyfriend.

As noted above, Dr. Ward should fully inform patients about circumstances in which he cannot provide care on moral or religious grounds, and this information should be readily available in time for patients to seek alternative care. Inasmuch as Dr. Ward is the only physician in a small town, it is likely that his personal position against induced abortion is well known in the community. However, patients in general and Theresa in particular may have no knowledge that Plan B® might in some instances act as an abortifacient. Then too, a physician should be consistent in his or her conscientious objection. To be ethically and morally consistent, a physician who objects to the use of post-coital steroids on the grounds that their effect in some cases may be to prevent implantation of the fertilized ovum should also object to the use of other forms of steroid contraception (eg, birth control pills) that affect the endometrium in ways that can prevent implantation.

Finally, two other important ethical dimensions illumine this encounter between Dr. Ward and Theresa Scholtz: beneficence, the physician's obligation to promote the well-being of the patient; and confidentiality, the responsibility not to divulge information to a third party. As regards beneficence, Theresa Scholtz has engaged in self-destructive behavior (binge drinking and unprotected sex). Simply providing her with a prescription for Plan B® without giving some attention to this behavior is not in her best interest nor does it contribute to her overall well-being. Dr. Ward's beneficence-based responsibility, at the very least, requires that he counsel Theresa about the dangers of her recent behavior and the possible benefits of confiding in her family.

As regards confidentiality, Theresa at age 16 is a minor. In most situations, physicians do not treat minors in nonemergent circumstances without the consent of a parent or guardian. Many state laws, however, protect adolescent confidentiality regarding diagnosis and treatment of sexually transmitted diseases, contraceptive counseling, and pregnancy. Dr. Ward probably knows almost everyone in town and is aware of their physical and emotional ailments and their socio-domestic circumstances. In a small community, the close relationship of the sole family physician with his patients does not diminish his ethical responsibilities, and it may complicate and intensify them.

In the future it is possible that Dr. Ward and other physicians will not be confronted with the necessity of prescribing Plan B® or similar medications, if the FDA approves these medications for nonprescription (over-the-counter) availability. The risks and benefits of such a decision are currently being debated.

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Commentary 2

by Karen E. Adams, MD, and Martin Donohoe, MD

This case illustrates a classic ethical conundrum: what to do when a physician's moral stance conflicts with a patient's request for care? Physician-assisted suicide and termination of pregnancy are examples of services that a reasonable patient might request but that a physician may refuse to provide on grounds of moral objection to the practice. Objecting physicians argue that these services fall outside of the realm of medical care, considering one or both practices to be murder. Participating in PAS, the physician contributes directly to the death of a human being. Some physicians see termination of a pregnancy in the same light, equating the life of the fetus to that of a living person.

Such a viewpoint rejects abortions as unethical and even immoral since it involves the taking of life. On the other hand, pro-choice observers argue that abortion is a legal right and patients are harmed physically and psychologically by delays in obtaining abortion services. They feel that the physician ought to provide the abortion or at least refer the patient to another physician who will. But this stance ignores the reality that conscientiously objecting physicians do not view lack of access to abortion services as harmful, but rather as beneficial, because the fetus can potentially remain viable and can grow to term. The opponents of abortion feel that, if the pregnant woman does not want to raise the child, she has the option of giving up the child for adoption, thus respecting both her life and the life of the child. If she is determined to obtain an abortion, she may do that herself without the help of her usual physician, who believes that even assisting her to find a provider makes him or her guilty by association. Although Dr. Ward in this case did refer Theresa to another physician, the barriers to timely care remain substantial due to her youth, the distance she must travel, and the short time during which emergency contraception (EC) is effective.

Weighing Rights and Responsibilities

Evaluation of such a case requires consideration of the obligations of the physician to himself or herself and consideration of the rights of the patient. What are the rights of the patient in this case? All women of reproductive age in the United States have the legal right to safe abortion services. Yet barriers to reproductive services are now substantial, and in recent years the government has raised more barriers: Diversion of federal funding to abstinence-only education, mandatory waiting periods and parental notification laws for teens seeking abortions, and the implementation of Targeted Regulation of Abortion Provider (TRAP) laws are only a few examples of the increasing obstacles to safe access to abortion services in the United States [1,2]. The outcry from the scientific community following the FDA's refusal to approve EC for over-the-counter use was based on the conclusion that this decision had

more to do with politics than science [3].

The scarcity of qualified physicians also impacts women's access to safe abortion. Eighty-seven percent of US counties have no abortion provider, including 30 percent of metropolitan areas [4]. The situation is worst in rural areas, where women may have to travel 100 miles or more to obtain abortion services or, as in this case, even to obtain EC [5]. This burden falls disproportionately on the young and the poor, who often do not have the resources to travel such long distances to obtain care. A hopeful sign is the new ACGME requirement that all OB/GYN training programs provide training in abortion techniques, with residents opting out only in cases of moral objection [6].

Conscientious Refusal to Treat

Although conscientiously objecting physicians do not see harm in the consequences of delayed or unavailable abortion services, the data regarding these consequences are clear, with higher complication rates for terminations at a later gestational age. The burden of traveling long distances to obtain care and the potential of carrying an undesired pregnancy to term simply due to unavailability of services are additional harms that should be considered. Horrific complications, including sepsis and death, were not at all unusual when abortion was illegal in the United States. Even today, some women, faced with an undesired pregnancy and no safe means of termination, may resort to desperate measures, potentially endangering their own lives. The rights of the patient in such a case may stand in direct conflict with the rights of a provider to remain true to his or her moral compass.

Physicians are not only physicians; they are also individuals whose moral thinking, like that of nonphysicians, has been shaped throughout their lifetimes by personal experience, religious beliefs, and the influence of role models [7]. Moral reasoning takes on special significance when a physician's values place him or her in conflict with patients who request a legal and socially sanctioned service such as pregnancy termination.

Dr. Ward's stance, although true to his own values, places his patient in an unduly burdensome situation. Asking Theresa to travel an extreme distance within a very short time to obtain EC constitutes a heavy burden when compared to the minimal burden on Dr. Ward to provide the medication, and that squarely places the obligation on Dr. Ward to provide the care. EC must be utilized within 72 hours after intercourse, when the embryo is still in a rudimentary multicellular stage. Thus, only the most adamant opponents would consider provision of this medication to be in the same category as first or second-trimester pregnancy termination.

Prescription of EC—a few pills—a matter of days after conception, as opposed to performance of a surgical procedure, places a much lesser burden on an objecting physician. Were Theresa asking for a surgical termination, a much more invasive procedure, the balance of burdens would be very different and Dr. Ward could ethically refuse to provide such care. He could reasonably be expected to offer referral to a willing provider for surgical termination, however, given the lack of availability of a second opinion in this rural community.

Theresa is already unusual in that she knows about EC; studies have shown that only one-fourth of reproductive age women in the United States have even heard of it [8]. If Theresa lived in California, Washington, New Mexico, or Alaska, she could obtain the EC medication over the counter, and if she lived in Hawaii a pharmacist could prescribe it for her. Other states are considering similar legislation to increase EC availability.

Women—and especially teens—need accurate information, access to contraceptive services, and readily available EC, with backup medical or surgical abortion if necessary. Residency programs should implement the ACGME requirement that, barring a deeply held moral objection, all residents participate in abortion training. Medical abortion protocols should be instituted in more clinics and physicians' offices. The American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics all support over-the-counter availability of EC. It is crucial in these politicized debates that physicians stand up for sound science and for the rights of patients to receive safe and effective care. Until EC can be obtained without a prescription, physicians should provide all women of reproductive age with instructions and prescriptions for EC at every office visit.

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