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Case and Commentary

Paternalism, Commentary 2

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Case

Lisa Morgan arrives in the office of Dr. Karen Anderson, her obstetrician/gynecologist. Dr. Anderson, who is going over her schedule for the day, hopes that Lisa is not pregnant again. Less than 2 years ago, Dr. Anderson had performed a therapeutic abortion for Lisa, who is now 20 years old and unmarried. The doctor's concerns are confirmed when her medical assistant, Elena, informs Dr. Anderson that Lisa is in the office seeking another abortion.

From the beginning of the office visit, Dr. Anderson is frustrated with the interaction. Lisa seems to be taking the situation lightly. Perhaps she is embarrassed, but her behavior is complicating a situation that is already uncomfortable for the doctor. Dr. Anderson intensely dislikes performing abortions but will do one when she thinks it is best for her patient, as with Lisa's first one. Dr. Anderson, who has a daughter about Lisa's age, does not want Lisa to regard abortion as a form of birth control.

Before agreeing to perform an abortion, Dr. Anderson brings up the topic of birth control. At the time of Lisa's first pregnancy, she had not been using any contraception. This time, she had been using birth control pills prescribed by Dr. Anderson, but she was forgetful, missing scheduled pills frequently by her own admission. Dr. Anderson suggests a longer-acting form of birth control, such as Depo-Provera (by injection) or an intrauterine device. Lisa cringes at the thought of shots, even as infrequently as 4 times a year, and says she knows women who have had bad cramping and even infections from IUDs. She wants to stay on the pill.

Dr. Anderson tries to persuade Lisa, saying that she is likely to forget her pills again, just as she did during the past few weeks. Dr. Anderson feels as though she is repeating the same words over and over again, and she insists, somewhat angrily now, upon Depo-Provera. Lisa still shakes her head vigorously, saying that she prefers pills to shots.

Dr. Anderson says, "Wait here, Lisa, I'll be back in a minute," and abruptly leaves the room to regain her composure. She vents to her assistant Elena, saying "I'm not making any headway with this girl. What else can I do? I don't want her to just choose another clinic, but I don't think using abortion as a form of birth control is healthy for this girl. I've got to try to educate my patients."

Commentary 2

Abortion seems to be unique among procedures doctors perform, in that physicians' personal distaste for performing them is considered reason enough not to do them. A physician who, for example, really hates to attend the births of children with Down syndrome, cannot tell her patients, "You really must have prenatal diagnosis and abort if Down syndrome is diagnosed, because I hate to do those births." Or, less morally

fraught, a doctor who finds setting bones distasteful, just does not like to do it, cannot say to a patient: "You really must stop skiing because I hate to set bones." But a physician who "intensely dislikes performing abortions" is allowed to have that influence her practice and even her patient's treatment.

Karen dislikes performing abortions: no reason is given. No reason has to be given, it seems, if it is abortion. Its "unlike-ability" is taken for granted.

Ms Morgan is a sexually active, fertile woman who has experienced her second pregnancy in less than 2 years. At the time of her first pregnancy, she was not using any contraception and is now somewhat erratically taking birth control pills. Unless there was a long unexplained period of sexual abstinence between the last pregnancy and this one, she has apparently been fairly successful in her contraception. A 20-year-old, demonstrably fertile woman who does not conceive for almost 2 years is almost by definition fairly effective in her contraception.

We now are faced with a conflict between what Karen feels comfortable doing and what Ms Morgan feels she needs to have done. We are being asked to think of Karen as maternal: she has a daughter Ms Morgan's age, we are informed, and she tells her assistant that she is worried about the girl's health and needs to "educate" her patients.

What if we were to provide Karen with convincing data that barrier contraception and early abortions every 2 or so years are physically safer for Ms Morgan than Depo-Provera or than an IUD? Would that ease Karen's discomfort? Would she so educate her patients? If so, then we can ask whether Karen is behaving paternalistically. Paternalism is not just about power: it is the power of the parent, a power used in the perceived best interests of the other. If I force a child to have a vaccine, even though he or she really hates having the shot, I am doing so in the best interests of the child, doing something I believe he or she will "thank me for later." That, I believe, is what marks a particular use of power as "paternalistic."

I think that is not the case here though: it is not the safety of early abortion for her patients that troubles Karen but the act of abortion itself. It is, then, rather disingenuous for her to say that using abortion as a form of birth control is not healthy for this girl or for us to be asking whether this is paternalistic behavior on her part. Karen does not like, intensely does not like, to perform abortions, and she does not want her patients to have them. She would like Ms Morgan, and presumably her other patients, to do whatever it is they have to do to avoid putting Karen in the difficult position of having to do something she dislikes doing.

I regard that as inappropriate and unprofessional and an attempt at abusing her power; I do not think it rises to a standard of paternalism.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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