

## **Virtual Mentor**

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### **Clinical Case**

#### **Patient Counseling and Matters of Conscience**

Commentaries by Farr Curlin, MD, and Rev Russell Burck, PhD

Amber Whittaker went to see her family physician about a sore throat. Amber, 19, and her family have been patients of Dr Christine Nowak for 15 years. The Whittakers and Dr Nowak are members of the same evangelical church, Riverwood Community Church, and they have grown to be friends over the past few years.

Dr Nowak examined Amber, performed a rapid strep test, which was positive, and informed her that she had a streptococcal pharyngitis. "Try not to kiss any boys this week," Dr Nowak said with a smile.

"Actually, now that you mention it," Amber said, "that's something I wanted to ask you about. My boyfriend and I have been together for more than a year now, and we've been talking seriously about marriage."

"That's great! I'm glad to hear things are going well," Dr Nowak said.

"Well, that's not all: we feel we're ready to start having sex, and I need to ask you to write me a prescription for birth control pills."

Dr Nowak paused for a moment, then explained, "You know, Amber, I appreciate you sharing this with me, but I imagine you know how I feel about premarital sex. As your doctor, friend, and fellow Christian, I think this is an unwise decision, and I can't in good conscience help you do something I think is wrong."

"But doctor, we've both thought about it, and we love each other, so why put it off any longer?"

"As a physician," Dr Nowak replied, "I'm committed to doing what's in my patients' best interest. And I believe, based on the Scriptures we both read and on our common understanding of God's nature and purposes for us, that sex is the consummation of a spiritual union between husband and wife. Sex is created by God to be enjoyed in the context of marriage, and saving it for that moment makes it all the more special. I realize that's difficult, and it's not what our culture at large believes. But if we call ourselves Christians, we need to carry our beliefs into every aspect of our identity? including something as personal as our sexuality."

#### **Commentary 1**

by Farr Curlin, MD

This case is particularly relevant in light of recent controversies regarding physicians and pharmacies who refuse to prescribe or dispense one or more types of contraceptives. The moral questions are similar in both cases.

In my experience, most within the medical profession would judge Dr Nowak's actions as unethical. In the medical literature, 3 reasons are typically invoked to justify the conclusion that Dr Nowak and others like her ought not to engage in this sort of dialogue with patients. I will briefly outline those here and point to a forthcoming essay [1] which considers them more thoroughly. First, physicians are thought to be insufficiently *competent* to discuss religion with patients. Dr Nowak may be familiar with Ms Whitaker's church, but she is neither a theologian nor a pastor, and it is not clear that she has the requisite knowledge to do justice to the complexities of faith and sexuality. Second, because physicians interact with patients from a position of unequal power, statements like those made by Dr Nowak are thought to be inherently coercive and threatening to patients' right to *autonomy*. Third, statements such as Dr Nowak's violate the commitment to religious *neutrality* which a physician's professional position requires. Presumably, Ms Whitaker seeks out Dr Nowak as a physician, not as a moral counselor. As such, Dr Nowak, by raising religious issues, crosses professional boundaries which require her to remain professional neutral as regards religion [2].

In the end, these arguments are insufficient to justify the conclusion that Dr Nowak actions are unethical. Parts of her actions may be less prudent than they could otherwise be, and a longer conversation could be had about the details of how to navigate situations of moral disagreement. Yet it remains that physicians have the moral freedom, and at times the moral obligation, to respectfully and candidly decline to participate in that which they judge to be immoral or otherwise not conducive to their patients' good. To explain why, it is helpful to return to the question posed to us.

We are asked, "How should physicians respond to patients who are engaged in behaviors that the physician believes to be immoral?" That is the question for the ethicist who necessarily stands at a critical distance from this scenario, but it is derivative of the more primary question which faces Dr Nowak, "How should I as a physician respond to patients who are engaged in behaviors that *are* immoral?" Here I hope it is self-evident that, whatever their legal obligations, physicians are not *morally* obligated to facilitate or otherwise participate in patient actions that are themselves immoral. Such an obligation would be logically self-defeating and would, to the extent that the right and the good mutually coinhere, profoundly undermine physicians' primary commitment to patients' good.

If Dr Nowak is not morally required to facilitate those patient behaviors that are not good, the relevant moral questions are whether it is good for Ms Whitaker to engage in premarital sex, and, if not, whether the prescription of oral contraceptives facilitates or participates in that behavior. Yet, I gather that the questions as I have just phrased them will strike some as beside the point because they suggest that Dr Nowak (or anyone for that matter) could somehow know that another person's sexual behavior is immoral. Indeed, in our day most seem to believe that religious notions about sexual

immorality are not notions about something real which is subject to discursive reason but rather belong in the private realm of “personal values.”

The problems with such ideas require more attention than I give in this setting, but I will clarify 2 points. First, ethical deliberation depends on the confidence that we can, even if only partially and imperfectly, discern that which is good (moral) and that which is not (immoral). If there can be no knowledge about what is good, then venues and dialogues such as this one become meaningless. Second, any real choice, such as that facing Dr Nowak regarding the prescription of contraceptives, is a moral choice which implicitly or explicitly expresses a moral judgment. One very important question is *how* Dr Nowak could know whether or not premarital sex is good for Ms Whitaker. That question requires a great deal of consideration, but regardless of *how* one makes such a judgment, it is clear that the judgment must and will be made.

All of this points clearly to a fundamental challenge of living in a plural society, namely that we do not all agree about what is right and good. What then should physicians like Dr Nowak do in contexts of moral disagreement with their patients? My rather unoriginal proposal is that physicians should respectfully engage in discourse with patients to discern the good and then seek to negotiate accommodations that do not require either to violate their consciences. Because it is moral discourse that is required, we see that concerns about competency, autonomy, and neutrality are misplaced. Competency is a term that refers to technique, but moral deliberation is not a technique. What is needed in cases such as these is the wisdom to discern how best to act given all of the contextual complications.

For example, although physicians are not required to participate in that which they believe is not good, it does not necessarily follow that the most prudent course of action is to try to persuade patients of the physician’s point of view. In a similar way, a physician may judge premarital sex to be immoral but judge the prescription of contraceptives to be moral because the latter may reduce the harms of the former. In regard to autonomy, Dr Nowak’s refusal to prescribe oral contraceptives cannot be a violation of patient autonomy unless autonomy requires physicians to provide whatever their patients request. If autonomy does not require physician participation in all cases, and I think it obvious that it cannot, then one must ask why it requires participation in this case.

Finally, the pretense of neutrality cannot be sustained in any case where a physician is asked to make a judgment, and such judgments are implicit in all deliberate human actions, such as the decision to prescribe contraceptives, or, for that matter, to prescribe anti-hypertensives. Rather than seeking an illusory neutrality, physicians like Dr Nowak should be candid about their own commitments and how those commitments influence their recommendations. For example, it would have been unethical for Dr Nowak to hide her religious convictions by telling Ms Whitaker that she could not prescribe an oral contraceptive because she was worried about its side effects. Respect for persons requires candor about the reasons for our recommendations.

Given the events of the past few weeks in the State of Illinois, I will take advantage of an opportunity to encourage fellow ethicists, clinicians, patients, and policymakers to exercise restraint in formulating policies that would require others to participate in that which violates their consciences [3]. We rightly challenge one another, argue with one another, and even persistently and respectfully badger one another in efforts to discern and persuade each other of the truth. But invoking the coercive power of the law necessarily does violence to any robust concept of religious freedom. Dr Nowak in this case has not imposed her values upon Ms Whitaker simply because values cannot be imposed. Ms Whitaker remains free to value that which she will and retains the legal right to seek to obtain contraceptives from another physician. On the other hand, if the law or the governing powers in the medical profession require Dr Nowak to prescribe contraceptives, they in effect coerce her to make a choice between violating her religious commitments or quitting the practice of medicine. Such policies would constitute grave and unprecedented restraints on religious freedom and would effectively preclude substantial segments of the US population from entering the medical profession.

Those who disagree with us (whether religious or secular) pose very real obstacles and introduce unavoidable inconveniences which complicate our efforts to live our individual and common lives according to the good as we understand it. The answer is not to coercively require some to participate in the aspirations of others, but for all to peaceably tolerate the disagreements and differences that cannot be avoided in a plural culture. In such a world as ours, it is the responsibility of physicians to respectfully and candidly seek the good of their patients, even when that good is something about which they and their patients disagree.

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### **Commentary 2**

by Rev Russell Burck, PhD

This case poses 2 specific questions, each of which introduces a far broader ethical inquiry. The questions, “Is Dr Nowak’s response to Amber ethical?” and “Why or why not?” force us to ask, “What is the good or not so good?” and “How do we determine what the good is?” [1]. The case also asks us, “How should physicians respond to patients who are engaged in behaviors that the physician believes are immoral?” That is a question about other people’s ethics, which my commentary addresses implicitly.

The Hippocratic Oath and the Oath of Maimonides recognize that physicians can exploit patients for their personal “needs.” When Dr Nowak talks about the teaching of their church about premarital sex, is that about herself or Ms Whitaker? Whether she brings her beliefs, her experience as a mature woman, and her membership in the same church into her care of her patient or leaves them at the door, whom is she serving?

Maimonides says, “Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.” Does this particular encounter with Ms Whitaker confirm the ethical guidance, the “established solutions” Dr Nowak has received? Or does it ask her to examine those established solutions with the possibility of changing them to develop “novel solutions” [1]?

Custom contributes to medical ethics by establishing solutions to common problems. Custom doesn't, however, prepare clinicians well to identify or resolve new ethics problems. Dr Nowak may therefore have to break new ethical ground for herself. That will be a trial and error process.

John Stuart Mill observes in *Utilitarianism* that the absence of an agreed-upon first principle has made ethics not so much a guide as a consecration of a man's actual sentiments [2]. We get beyond consecrating our opinions about the good by testing them.

A customary test of Dr Nowak's response asks about her rights. She has a right to express her views appropriately to her patients and to decide whether to fulfill their requests. As a physician, she voluntarily defers some autonomy to patients, but patient autonomy (self-rule) doesn't entail physician heteronomy (rule by others).

We are finished testing our solutions when they do not require us to address new problems either within ourselves or with others. Simply saying that Dr Nowak has the right to decline Ms Whitaker's request does not end the inquiry. We have to revise the original question and ask, “Is her action “ethically preferable”?”

Many other tests are available. I prefer *Clinical Ethics*, by Jonsen, Siegler, and Winslade [3]. They identify 7 goals of medicine. These goals make Beauchamp and Childress's principles (beneficence, nonmaleficence, respect for autonomy, and justice) specific [4]. Some of these goals of medicine pertain to Ms Whitaker's request, some don't. Promoting health and preventing disease (goal 1) and educating and counseling patients (goal 6) pertain, as does relief of symptoms, pain, and suffering (goal 2). Ms Whitaker is suffering from unconsummated love. Less pertinent are cure of disease (goal 3), preventing untimely death (goal 4), and improving functional status or maintaining compromised status (goal 5). Despite its prominence in medicine, avoiding harm in the course of care (goal 7) is at risk. If Dr Nowak prescribes the pills,

she will harm Ms Whitaker from her point of view, and if she doesn't, she will harm her from Ms Whitaker's point of view.

Regardless of Dr Nowak's beliefs about premarital sex, promoting health and preventing disease are paramount. That links directly to educating and counseling. In the sense of *educare*. Educating is more than telling. It "draws from" the other. Not drawing from Ms Whitaker, Dr Nowak inhibits her ability to educate and counsel. Instead she preaches.

Educating patients by asking, not just telling, leads to Jonsen, Siegler, and Winslade's next major category, *patient preferences*—what the patient consents to. We know Ms Whitaker's preferences. But why does she make *this* request of Dr Nowak? This question expands "*patient preferences*" to "*patient perspectives*." By inquiring into Ms Whitaker's perspectives on making love with her boyfriend, Dr Nowak would have been more able to prevent disease, promote health, and relieve suffering and to postpone the standoff between Ms Whitaker's request and her own conscience.

What is she asking of Dr Nowak? A different "gospel," "good news" from medicine that trumps the church's teaching about premarital sex? Permission to act out? Help stiffening her spine against an insistent boyfriend? Reconciliation of her church's messages with those of her own body? Questions like these could have opened the door for a deep conversation that could have integrated Dr Nowak's experience and her medical, religious, and personal convictions into her education and counseling of her patient and fellow church member.

A fundamental goal of medicine, Jonsen, Siegel, and Winslade say, is to improve or maintain the patient's quality of life (QoL). Concern about quality of life could easily prompt Dr Nowak to ask whether the 2 of them could talk about the pros and cons of this decision for Ms Whitaker's QoL. This conversation could include things that could go wrong with Ms Whitaker's plan, such as, sexually transmitted diseases or the effect of premarital sex on her relationship with her parents and her church.

*Contextual features* concern the good of stakeholders other than the patient. In this case, it is important to give explicit attention to Dr Nowak's own good. Here, when her integrity is at stake, it is important for Dr Nowak to be clear in her own mind where she stands and what her responsibilities are to her patient. For quite a while, she wouldn't have to tell Ms Whitaker anything. But there's a lot that she can ask. For example, "Could we talk about how are you thinking about our church's teaching concerning making love before marriage? Are you thinking about not staying in our church? (Remember—this conversation is confidential.) Another question that comes to my mind can be a little touchy, but it would be very understandable if you thought that a doctor might have an opinion that differs from the minister's. Could I ask if you had a thought like that?" And so on. What happens in that conversation will determine whether she needs to tell Ms Whitaker her point of view. Dr Nowak's relationship with others in the church may be at stake along with the church's teaching about sex and marriage. Dr Nowak's professional integrity may also be at stake: Is the physician-believer a tool of the church? Or a closet hypocrite?

The goals of preventing disease and educating and counseling commend deep dialogue with Ms Whitaker about the perspectives behind the preferences. Dr Nowak's professional preparation could have helped her inquire, listen, and still retain her right to say, perhaps a bit later in the conversation and more gently, everything that she said in this scenario. She had an opportunity to consider and test a novel solution for integrating her person values into her care of patients. The main problem of this encounter is less with Dr Nowak's response than with her lack of preparation to review a custom, and be open to revising it. Ethical deliberation can help with that.

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