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American Medical Association Journal of Ethics
February 2012, Volume 14, Number 2: 121-125.

JOURNAL DISCUSSION

Barriers and Biases: Ethical Considerations for Providing Emergency Contraception to Adolescents in the Emergency Department

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Miller MK, Plantz DM, Dowd MD, et al. Pediatric emergency health care providers' knowledge, attitudes, and experiences regarding emergency contraception. *Acad Emerg Med.* 2011;18(6):605-612.

Several ethical issues relating to the distribution of emergency contraception (EC) to pediatric patients are brought to light in the *Academic Emergency Medicine* article "Pediatric Emergency Health Care Providers' Knowledge, Attitudes, and Experiences Regarding Emergency Contraception" [1]. Miller et al. conducted a multicenter focus group study that unveiled several opinions regarding EC among health care professionals in urban pediatric emergency departments (EDs). The varying levels of knowledge, diverse attitudes, and practices discussed in the article point to implied biases and health care disparities related to emergency contraception distribution among pediatric patients.

The article begins with background on the state of unintended adolescent pregnancies in the United States. Despite a slight overall decline since its peak in 1990, the birth rate among U.S. adolescents is the highest among industrialized nations [2]. Although emergency contraception is available over the counter to women as young as 17 years old, many adolescent patients find themselves in the emergency department following unprotected intercourse. The authors identify barriers these adolescents encounter, focusing specifically on the knowledge deficits and personal opinions of health care professionals (HCPs) and state laws regarding conscientious objection. Citing a lack of data describing nurses' attitudes and knowledge, the authors set out to ascertain clinicians' attitudes, beliefs, and experiences regarding emergency contraception in pediatric emergency room encounters. It should be noted that the authors focus on current beliefs without discussing trends or changes over time.

The authors conducted a multisite focus group study in three freestanding urban pediatric teaching hospital EDs across the country. It is important to consider the potential selection bias of this population, which may not reflect the typical U.S. adolescent emergency room visit (for example, according to *U.S. News*, only about 1 in 30 U.S. hospitals has "deep expertise" in pediatric critical care) [3]. The methods involved a psychologist's using a discussion guide with open-ended questions to moderate 60-90-minute sessions comprising approximately ten physicians, nurse practitioners, or nurses. Later in the article, the authors acknowledge the limitations

of qualitative methods and the varied discussion content in the nonreproducible, semistructured group setting. Despite the variations from group to group, Miller and colleagues identified three major themes of conversation, which bring to light important ethical implications for adolescents who visit the ED following unprotected intercourse [4].

1. Attitudes and Beliefs toward Adolescent Sex and Contraception

Though “most” HCPs in the study supported adolescent contraception, the nurses in particular raised concerns about societal norms shifting to become more accepting of teenage pregnancy. The article lists the barriers to emergency contraception for adolescents perceived by the participants: “fear, availability, knowledge deficits, side effects, cost, transportation, need for HCP contact and prescription, embarrassment, lack of planning, and privacy issues” [4]. It would be interesting to follow up this perceived list of barriers with a survey of sexually active adolescents to elicit their perceived and actual barriers to reproductive care and contraception.

2. Attitudes and Beliefs Toward Emergency Contraception

Several quotes illustrate personal anecdotes, experiences, and biases about adolescent use of emergency contraception inherent in the sample nursing population. The authors recount that the nurses “expressed punitive attitudes” toward the adolescents’ “irresponsible behavior” [4]. Specifically, one nurse mentioned an adolescent niece getting kicked out of her parents’ house after using Plan B, and another nurse asked, “If you play the game, don’t you maybe have to pay?” Of course, pregnancy is a big price to pay for unprotected sex. Though it is understandable that clinicians may feel frustration with any patient noncompliance (whether in failing to take diabetes medication or birth control, failing to use the treadmill or condoms), it is ethically unacceptable for HCPs to penalize patients for their actions. Clinicians do not withhold insulin from patients in diabetic ketoacidosis to teach them a lesson; nor should a teenager be denied emergency contraception. Recognizing these attitudes and striving to thwart them in favor of the virtue of compassion is essential to providing appropriate and ethical patient care.

3. Barriers and Opportunities to Provision of Emergency Contraception

Social judgment. The authors note how most nurses in the study tended to favor assessing patients on an individual basis. It seems to be implied that the surveyed HCPs favor providing EC to smart, responsible patients like a Stanford-bound 17-year-old girl. What does this mean for patients of low socioeconomic status who cannot afford or receive regular birth control, much less support a child? Arbitrarily doling out emergency contraception to adolescents based on their status as upstanding citizens or their moral merit is ethically problematic. Professional integrity dictates that health care professionals have an obligation to practice medicine at the highest intellectual and moral standards, regardless of the socioeconomic or emotional level of the patient in question.

Provision of emergency contraception. Opinions about providing emergency contraception differed both by hospital location and between nurses, on the one

hand, and physicians and nurse practitioners, on the other. Adhering to the principle of justice requires that patients have equal access to care, which is at odds with the lack of nursing support for emergency contraception in the Midwest compared with the Northeast. Nurses seemed more inclined to put stipulations on access to emergency contraception such as the context of the intercourse. The article mentioned several comments in which rape or assault victims were considered more justified in receiving EC than patients who engaged in consensual intercourse. Again, the patient's intelligence or "head on her shoulders" affected nurses' perception of her and the treatment they were inclined to support [5]. The ethical duty to respect patients' autonomy necessitates that each patient's individual worth and value be acknowledged. Patients should be treated with dignity and due regard, and care should not be compromised by the clinicians' judgment. It should be noted that physicians and nurse practitioners did not seem to reflect these biased attitudes towards EC provision.

Emergency contraception knowledge and experience. Subjects reported confusion regarding "screening requirements, side effects, and legality of health care provision." Even physicians and nurse practitioners lacked comfort with knowing how and when to prescribe emergency contraception. Professionals are ethically obligated to know practice guidelines and be able to provide appropriate care. If HCP ignorance or discomfort is an issue, perhaps hospitals should make efforts to educate staff regarding care options, especially pregnancy prevention for adolescents.

Emergency contraception in the emergency department. While many HCPs identified preferable locations for the distribution of emergency contraception (namely, the patient's primary care physician [PCP]), the respondents seemed to understand why adolescents seek it in the emergency room. Even though the continuity-lacking ED may not be the ideal setting, the consequences of denying emergency contraception or referring patients to PCPs may be great, including the need for more invasive procedures or unwanted pregnancy. Data compiled by California's Healthy Families Program indicates that 6-27 percent of adolescents aged 12-18 may not visit a primary care practitioner on a regular basis [6]. For adolescents without a regular PCP, the ED may be the only place to turn.

Refusal. The article points out an important ideological dichotomy between nurses and the other HCPs. Nurses were more inclined to refuse providing emergency contraception on moral grounds, whereas nurse practitioners and physicians felt an obligation or "an oath" to provide information about it [7]. Ethically, the nurses are entitled to limit care obligations due to legitimate self-interests. The conscientious objection argument is, perhaps, the most compelling justification for refusing to offer emergency contraception to adolescents. The authors share a quote from the American Nursing Association's Code of Ethics, which prioritizes patient safety and the patient's best interest.

Education. The groups identified barriers to providing reproductive education including “time, HCP knowledge deficit, and lack of adolescent interest.” Though time and disinterest may be difficult barriers to overcome, correcting the HCP’s knowledge deficit is an important and attainable task. Assessment of the study participants’ knowledge of EC found it to be generally poor and of especial concern in the Midwest and among nurses [8]. HCP knowledge deficits may limit patient autonomy if patients are poorly informed when making decisions. Providing emergency contraception education to all HCPs should be incorporated by emergency medicine departments throughout the country so that patients can make knowledgeable care choices.

Screening and advance prescription were also common themes among the group discussions. Most clinicians did not support either action. Though screening did not seem to be a part of every patient encounter, questions about sexual history and the need for emergency contraception were asked of high-risk patients. These areas may warrant further investigation, though they do not currently seem to play a central role in the ethical debate surrounding the availability of emergency contraception in emergency rooms.

The article summarizes current care inconsistencies and the need for education of HCPs. The authors warn that social judgment often affects patient care, and they conclude that future studies of emergency contraception for adolescent patients in the ED are warranted. Yet, the perceptions and barriers discussed in the article also indicate the need for a universal ethical framework to guide clinicians’ actions and patient care. Not only should readers be informed of the biases and disparities, but action should be taken to avoid ethical injustices. Such actions should take the form of self-awareness on the part of health care professionals and educational efforts regarding EC.

References

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