Virtual Mentor
American Medical Association Journal of Ethics
October 2009, Volume 11, Number 10: 755-760.

CLINICAL CASE

Can Physicians' Contractual Obligations Limit Their Professional Obligations?

Commentary by Frank A. Chervenak, MD, Laurence B. McCullough, PhD, and Robert J. Walter, MD, DHCE

Dr. Charles, a gastroenterologist, had been volunteering one night per week at a charity clinic that was operated by a group of Roman Catholic physicians and nurses. Although these physicians and nurses started the clinic as a way to live out their Catholic faith, they welcomed volunteer staff members of any faith or no faith who wanted to treat the underserved in their clinic. There were many non-Catholic physicians who volunteered at the clinic, of whom Dr. Charles was one.

For some months he had been treating Ms. Bates, a 23-year-old waitress with no insurance who had Crohn's disease. Together, they were able to keep her disease under control with a drug regimen she could afford. In the process they developed a good patient-physician relationship, and she viewed Dr. Charles as her primary physician since she had no other regular doctor.

At one of her visits, after they had discussed her health status, she said, "Dr. Charles, I've got something else I want to talk to you about. I've got a boyfriend now, and we're having sex. I'm really worried about getting pregnant. I barely have enough money to take care of myself, especially with the Crohn's. I don't think I could manage if I had a baby. I know about condoms, but my boyfriend doesn't always use them. Is there anything you can recommend for me?"

Dr. Charles paused. He believed the Catholic Church's position on birth control could be bent when a woman's health might be compromised by pregnancy, and if Ms. Bates had come to him in his private clinic, he would gladly have counseled her about contraception. Indeed, he felt it to be his obligation as a physician to provide such counseling. He was aware that Ms. Bates did not have access to another physician due to her financial situation. It was this clinic's policy, however, to follow the teaching of the Catholic Church, and it did not allow clinicians to recommend any method of birth control except total abstinence or periodic abstinence (the rhythm method). He had known about this policy, but as a gastroenterologist had not given much thought that the issue would come up in his practice.

Commentary 1

by Frank A. Chervenak, MD, and Laurence B. McCullough, PhD

Whether or not Dr. Charles should provide contraception counseling to Ms. Bates is really two questions. We will address each in turn.

1. Is Dr. Charles ethically obligated to *offer* means of contraception that are not morally permissible in Roman Catholic teaching?

The ethics and law concerning the physician's role in the informed-consent process are well established. The physician is to identify, from among technically possible and physically available alternatives for managing the patient's condition, the diagnostic and therapeutic alternatives that are medically reasonable. In the language of medical ethics "medically reasonable" is beneficence-based: there is an evidence-based expectation that a diagnostic or therapeutic intervention will result in a greater balance of clinical goods over clinical harms for the patient as these are assessed from a clinical perspective. This is a professional obligation that all physicians have [1].

Individual or institutional limitations on this professional responsibility are ethically impermissible because the presentation of information about medically reasonable alternatives is independent of the patient's subsequent decision to accept one of the medically reasonable alternatives, which is a function solely of the patient's autonomy, not the physician's. The individual conscience of a physician or the moral commitments of a health care organization are therefore not threatened by the physician's fulfilling his or her professional responsibilities in the informed-consent process [2].

It follows from the concept of the physician's responsibility in the informed-consent process that the answer to the first version of the question is "yes." As a matter of strict professional responsibility. Dr. Charles is obligated to inform Ms. Bates about possible means of contraception. It should be added that this answer applies to all of the health care professionals employed by or volunteering their services in this clinic. The ethics of informed consent are not somehow distinctive or unique to physicians but also apply to nurses, physician assistants, and other health care professionals.

2. After offering all medically reasonable alternatives, should Dr. Charles *recommend* only those forms of contraception permitted by the clinic's religiously based policies?

In the informed-consent process, after having presented the medically reasonable alternatives (along with information about their clinical benefits and risks), the physician is ethically justified in recommending one of the medically reasonable alternatives when, in evidence-based reasoning, it is clinically superior to the other in its outcomes. In the language of medical ethics, such an alternative is ranked first in beneficence-based clinical judgment [1]. The clinic's policy, however, is based not on evidence but on religious commitments and values. To be sure, these are important and serious moral commitments, but they are not medically evidence-based and therefore should not influence or interfere with what Dr. Charles may or may not recommend. The answer to this second question is therefore "no."

Dr. Charles has a larger question to consider, though. Should he continue working in this clinic if he believes its policies might interfere with his providing optimal care to his patients, even if he expects such interference to be rare?

Organizational policies of the clinic that are not consistent with every physician's professional responsibility to patients in the informed-consent process are ethically impermissible for two reasons. First, the clinic is a moral cofiduciary with its physicians of all patients for whom the clinic assumes responsibility [3]. It follows that, as a cofiduciary, the clinic is ethically bound by the same standards of professional responsibility that its physicians and other health care professionals are, as we described above. Second, the organization is not ethically justified in invoking the moral integrity of the commitments of the Roman Catholic faith community out of concern that fulfilling professional standards of informed consent will somehow make the clinic responsible for the subsequent decisions of patients to use accepted, safe, and effective pharmacologic contraception in violation of the teachings of the Roman Catholic faith community. As we pointed out above, these subsequent decisions are the function solely of the woman's autonomy. It is therefore a mistake for the clinic to assume that there is a straight line between provision of information about pharmacologic contraception and a patient's election of it. After all, some women, having learned of the risks of such contraception, elect against it. Similarly, other women elect against barrier techniques or IUDs because they are not as effective in preventing pregnancy as these women prefer. Still other women will not accept forms of contraception that are inconsistent with their religious or other moral beliefs, including women who are not Roman Catholics.

It follows that, if the clinic does not recognize its cofiduciary responsibilities in the informed-consent process and change its policies, then continuing to work there violates professional integrity. The answer to this question is, therefore, "no." Dr. Charles should not continue to work in a clinic if its policies interfere with his providing optimal care to patients.

Does Dr. Charles have an obligation to advocate for change in policy given that patients at the clinic, such as Ms. Bates, might not have other options due to their poverty?

The counseling policies of the clinic do not pass muster in the professional ethics of medicine and this is the main reason that Dr. Charles should oppose them as a matter of cofiduciary responsibility to all of the patients who seek care at the clinic. It is ethically significant that patients like Ms. Bates are under serious economic constraints in their ability to gain access to medical care. Such patients may, in reality, not be free to seek contraceptive counseling elsewhere, a constraint on their autonomy to which the clinic should be responsive. But this is a buttressing reason for Dr. Charles (and all of the health care professionals in the clinic) to oppose the clinic's counseling policies. The main and unavoidable reason that he has such an obligation to the clinic's patient arises directly from professional integrity, i.e., practicing medicine to standards of intellectual and moral excellence. The standards

of moral excellence in the informed-consent process are not matter for compromise. Otherwise, Dr. Charles destroys his own professional integrity, which, ethically, he is not free to do. The answer to this last question is, therefore, "yes."

References

1. McCullough LB, Chervenak FA. *Ethics in Obstetrics and Gynecology*. New York, NY: Oxford University Press; 1994.
2. Chervenak FA, McCullough LB. The ethics of direct and indirect referral for termination of pregnancy. *Am J Obstet Gynecol.* 2008;199(3):232.e1-3.
3. Chervenak FA, McCullough LB. Physicians and hospital managers as cofiduciaries of patients: rhetoric or reality? *J Healthc Manag.* 2003;48(3):172-179.

Frank A. Chervenak, MD, is Given Foundation Professor and chairman of the Department of Obstetrics and Gynecology at Weill Medical College of Cornell University in New York City. He has collaborated with Laurence B. McCullough on scholarship and teaching in the ethics of obstetrics and gynecology for over 26 years, and together they have published more than 140 papers in the peer-reviewed medical and bioethics literatures. He is coauthor with Laurence B. McCullough of *Ethics in Obstetrics and Gynecology*.

Laurence B. McCullough, PhD, holds the Dalton Tomlin Chair in Medical Ethics and Health Policy in the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston. He has collaborated with Frank A. Chervenak on scholarship and teaching in the ethics of obstetrics and gynecology for over 26 years, and together they have published more than 140 papers in the peer-reviewed medical and bioethics literatures. He is coauthor with Frank A. Chervenak of *Ethics in Obstetrics and Gynecology*.

Commentary 2
by Robert J. Walter, MD, DHCE

Dr. Charles faces a situation in which his personal values conflict with institutional policy. As a physician with a fiduciary relationship to his patient, he seeks to act in the best interests of and in accordance with Ms. Bates' wishes—within the limitations of care for the underserved. Many physicians confront situations in which personal goods or values (religiously or secularly based) conflict with the values either of an institution at which they practice or perhaps even of the profession itself. How one attempts to negotiate such conflicts is not only a matter of moral integrity but of fulfillment of professional, fiduciary, and contractual obligations.

To gain insight into the present case, it may be useful to examine an analogous relationship. Joining a profession (taken from its Latin root *profiteri*, or "to profess") entails an "an active, conscious declaration, voluntarily entered into and signifying willingness to assume the obligations necessary to make the declaration authentic" [1]. A profession has a code of conduct and values and an expectation that

individuals who enter into the profession will abide by them, sublimating or setting aside personal values in favor of the shared goods promoted by the profession. The key distinguishing feature is a voluntary willingness to assume the shared values upon entry into a specific profession. Such an act has been called a "covenantal relationship" implying a strong obligation and responsibility to uphold the shared goods of the profession [2]. This covenantal relationship contrasts with differing levels of obligation that derive from other types of relationships.

It may be argued that Dr. Charles has entered into a "contractual relationship" to provide services at the charity clinic. He now finds his personal values in conflict, not necessarily with the covenantal values of the medical profession as in our analogy, but with those of an institution that has a narrower set of moral norms than the profession. This conflict exists within the contractual relationship between an individual and an employer. While he may not have anticipated a conflict within his subspecialty of practice, it may be said that Dr. Charles either explicitly or implicitly agreed to abide by this set of moral norms in voluntarily entering into practice within this facility. Hence, it could be argued that direct contraception counseling is construed as a violation of his contractual obligations with this particular institution.

Medical necessity and limited access to resources, however, also play a role in the gravity of the situation. While Ms. Bates' medical condition (Crohn's disease) would not directly jeopardize her health or that of the fetus during pregnancy, there is the problem of limited financial resources if pregnancy occurs. Would Ms. Bates have the resources to adequately care for the child and would those demands place a disproportionate burden upon her, perhaps even requiring a diversion of financial resources away from her own medical care to the potential detriment of her health? Ultimately, Dr. Charles must proceed in a manner that is in line with his own conscience and understanding of good medical practice, while recognizing that he is undertaking an act of conscientious objection and may be subject to contractual penalties for diverging from the institution's established moral code and his obligations to uphold them. It might be argued that the contractual relationship establishes a relative set of obligations and responsibilities that must be carefully analyzed and evaluated, even though they may be of a differing and perhaps less absolute quality than those corresponding to his covenantal relationship with his profession. Dr. Charles must evaluate his potential actions in light of his contractual obligations in the context of his fiduciary responsibilities to the patient at hand.

While the options available for specific action within the charity clinic may be limited, Dr. Charles can arrange continuity of care for Ms. Bates should he deem it medically necessary that she receive contraception counseling and access to resources. Although Ms. Bates' lack of access to traditional health care and her probable inability to obtain services elsewhere hinders a direct transfer of care, a few options may be proposed. With regard to the procurement of contraceptive methods, Dr. Charles may recommend referral to a facility that provides resources to low-income patients (such as family planning organizations). This recommendation would raise the issue of moral complicity, but, it may be argued, the material

complicity (rather than formal complicity) that results would not necessarily violate his contractual obligation to the clinic. Likewise, should Dr. Charles find it necessary to counsel Ms. Bates directly, such counseling could take place at Dr. Charles' primary institution where these particular restrictions are not in place. It could further be argued that Dr. Charles has no obligation to bill for services rendered at his primary institution given previous billing at the charity clinic. While this might be viewed as more formal than material complicity, such actions would need to be evaluated in light of his contravening contractual obligations.

Having realized the potential for conflict with this case, Dr. Charles is challenged with the question of whether it is acceptable to continue in his employment at the charity clinic. His discussion is contingent on several factors: the institution's reaction to his actions (if the administration becomes aware of them or he makes them aware), the likelihood of similar situations occurring, and an evaluation of the strength of the contractual obligations and responsibilities placed upon him during his employment at the charity clinic. In light of his experience in this situation, Dr. Charles may be inclined to advocate for policy revision to assist patients in similar circumstances. While there may be many barriers to change, given the hierarchical structure of the Roman Catholic Church and adherence of each institution to those shared ethical and religious directives, Dr. Charles must again weigh the potential benefits of rightfully advocating for what he believes is in the best interests of his patients against the potential harms of doing so under penalty of violation of his contractual obligations to the institution.

References

1. Pellegrino ED. Toward a reconstruction of medical morality: the primacy of the act of profession and the fact of illness. *J Med Philos*. 1979;4(1):48.
2. May WF. Code, covenant, contract, or philanthropy. *Hastings Cent Rep*. 1975;5(6):29-38.

Robert J. Walter, MD, DHCE, is completing his residency in internal medicine at Walter Reed Army Medical Center in Washington, D.C. Prior to completing his medical degree at the Loyola University Chicago Stritch School of Medicine, he received a doctorate in health care ethics from Duquesne University and currently serves as a member of the ethics committee at Walter Reed and as a teaching fellow at the Uniform Services University of the Health Sciences, providing instruction in medical ethics for the F. Edward Hebert School of Medicine.

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 on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2009 American Medical Association. All rights reserved.