

CASE WITH COMMENTARY

Should Clinicians Challenge Faith-Based Institutional Values Conflicting with Their Own?

Commentary by Jane Morris, MD and Kavita Shah Arora, MD, MBE

Abstract

Catholic health care organizations generally prohibit their employees from prescribing contraceptives for the purpose of birth control. This restriction might go against a clinician's own beliefs and the explicit wishes of a patient. In this case, Dr. N is being asked by a patient, Ms. K, to code oral contraception as treatment for acne, a noncontraceptive benefit of birth control pills, although both parties know Ms. K's primary desire is to prevent pregnancy. We examine the legal and moral arguments surrounding contraceptive provision in this case and offer guidance for how Dr. N and Ms. K might work to find a tenable solution.

Case

Ms. K is a 19-year-old college student, home for the summer. Today, she is scheduled for a routine checkup with a new attending family physician, Dr. N. At the appointment, Ms. K presents as a healthy and energetic college student with minimal family risk of illness. Dr. N notes that Ms. K is sexually active and has had two partners in the last 6 months and asks Ms. K if she has been using contraception or protection from STIs during sex. "I use condoms every time. But I would be a lot more comfortable if I had birth control. Could you prescribe some for me?"

Dr. N agrees that she would benefit from an oral contraceptive but clarifies, "I'm not allowed to prescribe that for you here since this is a Catholic health organization."

Ms. K responds, "I know it's Catholic, but my friend comes here to get it, and her physician codes it as acne treatment." Dr. N considers that Ms. K's request for contraception is reasonable as a legal medical service and so prescribes the combined oral contraceptive pill (COCP) for Ms. K. Dr. N wonders whether to code it as acne treatment.

Commentary

Dr. N faces a difficult quandary: How should a clinician go about exercising her personal values when they clash with her employer's? Dr. N's choices fundamentally boil down to several possible options. She could choose not to prescribe at all, citing the *Ethical and*

Religious Directives for Catholic Health Care Services, established by the United States Conference of Catholic Bishops, which set rules for Catholic-affiliated health care organizations nationwide.¹ The Catholic Church views contraception as separating sex from the purpose of procreation within a marriage and therefore “cannot approve” contraceptive methods.¹ The *Directives* explicitly prohibit Catholic health institutions from promoting or condoning contraceptive practices, although such institutions “should provide, for married couples and the medical staff who counsel them, instruction both about the Church’s teaching on responsible parenthood and in methods of natural family planning.”¹ Dr. N could also choose not to prescribe COCP but instead refer Ms. K to a clinician outside the Catholic health system. Alternatively, Dr. N could opt to prescribe COCP, either for acne, as Ms. K’s friend’s doctor allegedly does, or for an alternative diagnosis for which Ms. K legitimately qualifies. Contraceptives, including oral contraceptive pills, are also appropriate therapies for a range of medical diagnoses including abnormal, irregular, or heavy menses; endometriosis; fibroids; and acne.² On the most extreme end of the spectrum, she could opt to prescribe COCP as contraception outright. Dr. N’s choice must balance respect for Ms. K’s autonomy as a patient, her own beliefs, and legal and moral considerations in executing her responsibilities as an employee of a Catholic health care organization.

Legal Considerations for Prescribing Contraception in a Catholic Health Care Institution

The United States Supreme Court clearly established a woman’s right to contraception as early as 1965 in *Griswold v. Connecticut*. This right was explicitly extended to unmarried women in *Eisenstadt v. Baird* in 1972 and to minors of at least 16 years of age in *Carey v. Population Services International*.³ These decisions hinged on the Court’s interpretation of a right to privacy, which, while not explicitly stated in the Constitution, extended primarily from the Due Process Clause of the Fourteenth Amendment.⁴

Despite COCP being a safe, evidence-based therapy and the American College of Obstetricians and Gynecologists (ACOG) supporting access to and reimbursement for all types of contraception, including COCP,² Catholic institutions can block clinicians from prescribing contraception through contractual obligations that fall outside the boundaries of professional organizations such as ACOG. According to the *Directives*, “Catholic health services must adopt these Directives as policy ... [and] require adherence to them within the institution as a condition for medical privileges and employment.”¹ Dr. N’s contract almost certainly prevents her from prescribing COCP for contraceptive reasons. Dr. N must then decide between protecting her job—a legitimate self-interest that also ensures her ability to care for future patients—and protecting the privileged relationship between physician and patient. The *Directives’* dictum is not an empty threat: Catholic health care organizations have terminated employees’ contracts for providing contraception.⁵ The *Directives* do not clearly state whether referring to a clinician outside their purview is permitted, but doing so would violate the spirit, if not

the letter, of the *Directives'* dicta given that the clinician would be complicit in the eventual provision of contraception.

Most of the extant policy regulating the exercise of individually held beliefs in the medical workplace focuses on [employees' right to refuse](#) to participate in activities that are incompatible with their values. Broadly, these laws prevent entities from discriminating against persons who refuse to perform certain services—such as end-of-life care, abortion, contraception provision, and sterilization—as a matter of conscience. In the years after *Roe v Wade* (1973), such laws were limited to employees of government agencies, but state laws now exist that allow employees of private institutions to refuse to provide services or prescribe birth control.⁶ Dr. N's case, on some level, represents the polar opposite: a clinician wanting to provide affirmative care but curtailed from doing so based on an institution's religiously derived policies. Unfortunately, case law and policy seem to be largely silent in this area, providing little legal protection for Dr. N should she attempt to defy her institution and openly prescribe contraception for the purpose of pregnancy prevention.

If Dr. N were to provide Ms. K her desired oral contraceptive under the false diagnosis of acne, the legal ramifications could result not from the provision of contraception itself but from the reason she gave for prescribing it. The US Code defines health care fraud as "knowingly and willfully execut[ing] ... a scheme or artifice—(1) to defraud any health care benefit program ... in connection with the delivery of or payment for health care benefits, items, or services."⁷ By submitting a falsified diagnosis, acne, for coverage by an insurance plan, even when the treatment, COCP, would be covered under a different diagnosis, Dr. N would be committing fraud. [Health care fraud](#) is considered a federal criminal offense that can carry a federal prison term in addition to hefty fines.⁸

Moral Arguments for and against Contraception Provision

As mentioned earlier, the Catholic Church cannot approve contraceptives because they separate sex from reproduction.¹ In the Catholic Church's view, "[m]arriage and conjugal love are by their nature ordained toward the begetting and educating of children."¹ Extramarital sex is not mentioned at all in the *Directives*, an omission which fails to take into account that over 90 percent of Americans have sex prior to marriage⁹ and that 40% of births in this country are to unmarried women.¹⁰ Even Catholic women and men in America, by and large, do not abide by this church decree in their own lives. The Guttmacher Institute reported in 2016 that 89% of US Catholic women at risk of pregnancy use some form of contraception and 68% use sterilization, hormonal birth control, or an intrauterine device (IUD).¹¹ Only 2% of US Catholic women use natural family planning, the Church's only approved form of birth control.⁹

As an employee of a Catholic health care institution, Dr. N has a duty to her institution to provide care in a manner consistent with its mission, despite the widespread use of

contraception among US Catholics. However, Ms. K is under no obligation to subscribe to the institution's moral principles. As an autonomous decision maker, she is seeking a reasonable, legal, and medically appropriate service within the realm of primary and preventative health care, which she is being refused due to principles she does not share. Dr. N must also examine the consequences of Ms. K not being able to attain her desired contraceptive method. In this case, a primary consequence could be unintended pregnancy, which would result either in abortion or in a pregnancy conceived, and a child possibly delivered, outside of wedlock—both options that the Catholic Church, which governs Dr. N's health care organization, opposes.

If Dr. N is unable to provide Ms. K with her desired form of contraception, she should refer Ms. K to a clinician outside the Catholic health care system. She could either do so explicitly, by formally transferring care to another clinician, or unofficially, by telling the patient about other health care organizations in the community that could provide more comprehensive care. ACOG states that referral is ethically necessary in cases of moral or religious objection.¹² The American Medical Association (AMA) states that a clinician "should offer impartial guidance to patients about how to inform themselves regarding access to desired services" if formal referral is unacceptable to the clinician—for example, in cases of "a deeply held, well-considered personal belief."¹³ However, referrals can impose burdens unjustly on those with fewer resources, particularly if the referral would put the patient outside his or her insurance network. Those patients with fewer resources and less health literacy will have greater difficulty in seeking and obtaining care from the referred clinician.²

It is unclear whether insurance or geographical constraints would prevent Ms. K from accessing another clinician outside the Catholic health care system. Groups such as Planned Parenthood provide a safety net for those with no clinician who can prescribe contraception but do not represent a feasible long-term solution, given attempts to defund Planned Parenthood and other reproductive health care organizations and that there are some states and many counties without access to Planned Parenthood or similar clinics.¹⁴ Thus, while referring to another clinician outside the Catholic health care system might be an expedient option for Dr. N, it fails to address the issue of contraception provision in a systemic manner.

The Catholic Church "does not consider at all illicit" use of medical therapies to cure diseases "even if a foreseeable impediment to procreation should result there from—provided such impediment is not directly intended for any motive whatsoever."¹⁵ It would be permissible to use birth control when the intent of the medication is for something other than pregnancy prevention if it is consistent with the principle of "double effect," whereby the effect of the action that is presumably "good" (eg, treating a medical condition such as acne) is intended and has more weight in justifying that action than does a consequence of the action that is merely foreseen and possibly "bad" (eg,

pregnancy prevention).¹⁶ To meet the standard of double effect, the good effect not must not only outweigh the bad effect but also come about as a direct consequence of the action—rather than as a secondary consequence of the bad effect—and the bad effect must not be actively willed.¹⁷ In fact, the double effect is only permissible if the bad effect cannot be avoided without failing to attain the good effect. However, in this case, since both Dr. N and Ms. K are well aware that the primary purpose of contraception is not treating acne, the principle of double effect cannot be used with sincerity to justify prescribing COCP.

Conclusion

As her physician, Dr. N has a responsibility to provide Ms. K with information adequate to make an appropriate, safe, and legal medical decision, which in this case is provision of birth control. In this case, Dr. N should probe Ms. K's medical history for an alternate but subjectively demonstrable diagnosis (such as abnormal uterine bleeding, dysmenorrhea, or acne) for which birth control is a medically accepted therapy so that she can prescribe Ms. K's desired contraception on the basis of the principle of double effect. If she is unable to make a diagnosis, Dr. N has a duty to inform Ms. K that she does not provide contraception for the sole reason of preventing pregnancy and to refer her to someone whose employer does not restrict prescribing patterns.

Outside of her encounter with Ms. K, Dr. N can also make some changes to facilitate the full range of care for all patients, particularly those who are socioeconomically vulnerable. For example, Dr. N could make sure that every patient is aware of her inability to prescribe contraception at the time the appointment is made, so that patients can choose to seek another clinician without first having to walk away from Dr. N's office empty handed.

The institution also has a responsibility to ensure that provisions are made to cover the full range of medically appropriate therapy, even if this means transfer to a non-Catholic institution if a medical service is not available.¹⁸ In this manner, Dr. N can balance her duty to her patient, her institution, and the values that govern her profession.

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Dr. Arora serves on the American College of Obstetricians and Gynecologists Ethics Committee and the American Society of Bioethics and Humanities board of directors. Dr. Morris had no conflicts of interest to disclose.

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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