Response to Commentators on “Conscientious Objection and Emergency Contraception”: Sex, Drugs and the Rocky Role of Levonorgestrel

Robert F. Card, State University of New York, Oswego

I thank the thoughtful commentators on my essay. Their contributions have deepened my grasp of the relevant issues. Unfortunately I cannot discuss each selection in turn, but will instead focus on several commentaries that purport to offer the most serious objections to my argument.

Farr Curlin (2007) argues that my paper only addresses “straw-men” (sic) arguments and fails to accurately state the reasons that drive opponents of dispensing emergency contraception (EC). Curlin goes on to present several of the “real” arguments in support of medical providers’ right to refuse to dispense EC, yet curiously he does not provide citations to the sources of these arguments. My paper does: for instance, members of Pharmacists for Life International claim that they will not dispense EC since this constitutes doing harm to human life and hence violates the Hippocratic Oath (Stein 2005). My essay certainly does not purport to examine every conceivable reason, but it does formulate and closely examine the reasons offered by the most vocal proponents of providers’ rights to refuse to dispense EC.

Curlin offers two arguments supporting conscientious refusal of EC that he believes I willfully neglect, one of which states that providers may refuse “because a) although contraception is ethically permissible, causing the death of a human embryo is not; and b) the good of preventing a pregnancy is not proportionate to the gravity and the risk of causing the death of a human embryo by using EC” (Curlin 2007, 30–31). As I understand it, reason (a) states that providers may refuse because a) although contraception is ethically permissible, causing the death of a human embryo is not morally equivalent to abortion and is therefore morally wrong. Reason (b) states that the good stemming from EC is not worth the risk of causing the death of a conceptus, given that it possesses full moral status. In my paper, I examine the relationship between EC, abortion and the risk of harming zygotic life in depth (Card 2007, 10 ff.); I discuss the empirical literature on the purported “post-fertilization effect” as well as the relevant ethical principles. Curlin conveniently overlooks this fact, however. Nor does he grapple with the deep problem associated with conscientious refusal of EC that I identify: providers conscientiously object even though they cannot know whether the phenomena to which they object in fact exists. This is the case for those who object based on a presumed comparison between EC and abortion, since fertilization cannot be detected within the seventy-two hour “window period” during which EC must be taken in order to be effective. This point makes such claims distinct from other instances of conscientious objection. The second of the “two most common arguments against providing EC” (Curlin 2007, 30) comes in four lengthy parts and is hardly the sort of reasoning one might hear in a doctor’s office or at a pharmacist’s counter. Essentially, the argument maintains that providers are not morally obligated to provide EC except in cases of sexual assault because “humans ought always to act in accordance with their nature,” and since human sexuality contains a “procreative and unitive aspect,” any action which intentionally and directly separates these two aspects of sexual intercourse (such as the use of EC) is illicit (Curlin 2007, 30) What is the precise relevance of this reasoning to the debate at hand? The case focused upon in this discussion is that of a woman who has engaged in sexual activity, fears an unintended pregnancy, requests EC, and is denied by a provider. In Curlin’s hands, the provider’s reasoning has nothing to do with harming zygotic life but with an unfavorable judgment of women who wish to engage in intercourse without procreation. The medical professional here seems to conscientiously object to women engaging in sexual intercourse without having to ‘face the consequences’ of their behavior (cf. Brody and Night 2007, 17). This “moral” reason is nothing more than a dressed up sexist rationale for allowing providers to punish women for their perceived sins (in the view of the physician or pharmacist). Needless to say, this is not part of the proper role of medical professionals.

Address correspondence to Robert F. Card, State University of New York, Oswego, Department of Philosophy, Oswego, NY 13126. E-mail: rcard@oswego.edu
Curlin (2007) correctly states my position, that providers are obligated to provide EC even if they have a conscientious objection. My central argument is that practitioners are medical professionals and professionalism gives rise to moral obligations to one’s patients; this raises the bar for what constitutes an acceptable reason to refuse care. Since there is at best a prima facie right to conscientious objection, because (as I argue) the reasons offered for refusal fail to meet critical scrutiny, providers have a professional ethical obligation to dispense EC. This cannot be right according to Curlin, given the centrality of conscience to ethics and the fact that “conscience is the limb on which medical ethics sits” (2007, 31). Curlin offers no explication of this rhetorical flourish; on the face of things, this sounds like meaningless bluster. Yet Curlin pursues this theme by asking, “what is a conscientious objection, but an individual’s judgment that it would be unethical for him or her to act in a certain way?” and stating that, “whatever reasons one might give for acting against conscience, they cannot be moral reasons” (2007, 31). This discussion cries out for clarification. Curlin might be saying that acting in accordance with conscience is always morally correct and asking that another violate his or her conscience is never ethically appropriate. Curlin suggests this idea when he says “moreover, all ethical arguments are appeals to conscience. As such, acting conscientiously is the most fundamental of all moral obligations” (2007, 31). On this line of reasoning, Curlin is committed to an implausible ethical subjectivism as part of his conscience-based ethics. As I have argued elsewhere (Card 2004, 6), ethical subjectivism—the view that a person’s feelings or beliefs are the only possible means to morally justify an action—implies that one’s actions are morally correct by definition. The only possible instance in which one might act wrongly on ethical subjectivism would occur in a case where one acts in a way that seems to be inconsistent with her or his own feelings or beliefs. Yet one must have approved of one’s own actions in some manner, at least at the time the action was performed. This ethical view is implausible since it would make the actions of (e.g.) serial killers and genocidal dictators morally correct.

Curlin (2007) might instead be saying that actions not in accordance with conscience cannot be moral in character; they simply are not moral reasons. Only personal reasons sanctioned by conscience constitute moral reasons on this view. This possible line of reasoning raises the interesting question of how to determine the moral content of reasons offered as part of asserting a conscientious objection, as well as the question of how to consider competing claims in such cases. Even granting that such conscientious objectors assert moral reasons, these are offered in a public context while the objector is fulfilling his or her role responsibilities—points ignored by Curlin. These facts affect how we ought to weigh these asserted reasons. If we follow Curlin and hold that reasons given for acting against conscience are not moral reasons, then we cannot morally criticize (e.g.) firefighters who conscientiously object to extinguishing a fire at an abortion clinic or schoolteachers who do not wish to teach atheists on ethical grounds (LaFollette and LaFollette 2007, 251). This is absurd. Curlin imports an undefended conscience-based ethical viewpoint into his commentary that infects all the rest; the definition of ‘conscience’ cited at the outset of his essay does not provide even the beginnings of offering a respectable philosophical basis in support of his claims.

Carson Strong (2007) argues that I unjustifiably eliminate the referral option and misconstrue the empirical literature regarding the mode of action of Plan B/levonorgestrel (LNG). I will address both of these arguments and conclude that his criticisms are not successful.

Strong (2007) notes the following argument from my paper: since the referral option may cause harm to patients—such as those that live in underserved and/or rural populations—the moderate view (consisting in referral to a willing provider) is flawed. He argues that it does not follow from this point that the referral option should be rejected and adds, “after all, one could hold that in the type of scenario in question—that is, when non-dispensing would cause significant harm—the option of referring is overridden by the interests of the patient” (Strong 2007, 32). In reply, I do not maintain that based on this reason alone, the referral option is to be rejected. I do argue, however, that this consideration does show that the referral option is not as ethically unproblematic as some believe—in particular, for thinkers such as Cantor and Baum (2004), since they are the focus of my discussion in this part of the paper. Strong’s quote above is noteworthy since it suggests that he may think pharmacists are required to dispense medications even given their conscientious objections to doing so. If so, it is not clear that Strong disagrees with my thesis as vigorously as he makes it seem in his commentary.

Strong also argues that my claim that public confrontations between pharmacists and women requesting Plan B compromises patient confidentiality provides no good reason to reject the moderate view. A pharmacist could step to a less public place or refer the matter to a willing pharmacist (Strong 2007, 32). Once again, I do not argue that this reason alone undermines the moderate view. Mine is a cumulative case; an essential part of my argument against the moderate view maintains that there is no intrinsic moral difference between filling a script oneself versus referring to another professional to dispense the medications. I find implausible Strong’s suggestion that the pharmacist in a large chain pharmacy will be able to step to a less public place. The fact that women typically meet with pharmacists within range of a magazine rack suggests something about pharmacists’ role. They are public professionals whose main function is to provide convenient access to medications. This setting certainly does not comport with the requirements of the Hippocratic Oath, which explains why doctors (as opposed to pharmacists) meet one-on-one with patients unless the (adult) patient consents to other arrangements. Quite simply, pharmacists differ from physicians, and perhaps these differences should be taken into account when assessing claims of conscience. On this matter, Strong says, “one might even hold that if there is no way to refuse to fill the pre-
The American Journal of Bioethics

scription without a public conversation that would breach confidentiality, then in those circumstances the right to refer is overridden by the patient’s interests” (2007, 32–33). Again, we find that Strong seems to agree with my thesis that pharmacists may be professionally obligated to dispense a medication even given their conscientious objections.

Strong’s second main criticism is that my argument rests on the false assumption that LNG acts solely by interfering with ovulation and I mistakenly treat this presupposition as a settled matter (2007, 33). Instead, Strong suggests it might be the case that LNG interferes with implantation, which would bolster the position of the conscientiously objecting professional. In my discussion, I do recognize explicitly that the precise method of action of currently available EC is not precisely known, and for this reason, I take up the argument of the very astute professional (Card 2007, 11). Strong inexplicably neglects this section of my article. In this part of the discussion in the paper forward, it is presumed that “pregnancy is equivalent to fertilization (or, at least, that fertilization marks the point at which an individual with moral standing exists)” (Card 2007, 11). This imagined very astute professional offers a distinctive argument since this reasoning presumes that if fertilization has occurred and such a woman receives EC, then something morally wrong happens. Of course, for the objecting professional’s action to be morally wrong on this line of reasoning, it must be possible that EC has post-fertilization effects. If that was impossible, this reasoning would make no sense (and I would not need to address it)! Clearly I do not consider the claim in question—i.e., post-fertilization effects do not exist—to be a settled matter in my paper.

Strong (2007, 33) specifically attacks my argument by claiming that LNG has post-fertilization effects by referring to the work of Durand et al.:

They report that late follicular phase administration of LNG reduces levels of glyodelin-A in uterine fluid, suggesting a possible mechanism of action in addition to interference with ovulation. Glyodelin-A has an immunosuppressive effect and may play a role in implantation by preventing the uterus from recognizing the pre-embryo as histologically “foreign”. It is hypothesized that reduced levels of glyodelin-A might result in the rejection—i.e., non-implantation—of the pre-embryo (2005, 456).

Strong’s point is that Plan B may also act to inhibit implantation by decreasing uterine receptivity, thereby showing that it has post-fertilization effects. While I certainly appreciate the inclusion of additional empirical information, in his discussion of this study Strong offers a misleading picture of the scientific evidence. In fact, the precise study he chooses to focus upon does not strongly support the view that Plan B sometimes directly interferes with implantation. Strong is correct to report that in this study there were diminished amounts of glyodelin-A in one group of the women who took LNG. Yet, in this study the level of glyodelin A was affected only in women who took LNG before the luteinizing hormone (LH) surge; taking LNG before the LH surge normally prevents ovulation from occurring (or results in the release of an ovum that cannot be fertilized). This interpretation suggests that EC may simply be doing its job by preventing ovulation; as Davidoff and Trussell put the point, “the glyodelin A effect may thus be an epiphenomenon, the result of an absent or inadequate LH surge rather than a direct link in the causal pathway of contraception” (2006, 1776). The upshot is that even the empirical study highlighted by Strong is consistent with the hypothesis that the primary mechanism of action of Plan B involves inhibiting or disrupting ovulation. All reasonable persons recognize the futility of claiming to prove definitively that a certain mechanism of action does not exist; all one can honestly say is that all existing evidence fails to determine such a causal link. However, Strong’s argument is weak: it fails to cast doubt upon the discussion of the mechanism of action of Plan B as this is utilized in my paper.

In conclusion, I was inspired to write this article in order to examine some possible moral justifications for conscientious objection with respect to EC, given that objecting providers seemed to be under no obligation to even state their reasons for refusal. To the extent that this paper spurs further elaboration and evaluation of these reasons, I will consider it a success.

REFERENCES


Queries

No Queries