- What should the doctor recommend?
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- Does it matter that El Salvador is a democracy and a majority supports highly restrictive abortion laws?
- Does it matter that according to a recent Pan American Health Organization guidance document, all governments are bound by a duty to provide information, respect the right to choose, and provide access to comprehensive reproductive health care and social support to women affected by ZIKV and their children?(2)

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COMMENTARY

When fiduciary duty clashes with duty to the state

RAKHI GHOSHAL

Abstract

In their case study Cash and Castro discuss a situation where a physician's duties to the laws of her land stand in conflict with her fiduciary duties to her patient. This present commentary is a response to the situation they describe, and it engages with the issue of conscientious objection in medicine, to argue that the ethical responsibility of the physician should be tilted in favour of the patient, especially when the laws of the land are regressive and harmful.

Despite the reporting of a few cases of Zika virus (ZIKV) in India (1), ZIKV did not turn into an epidemic the way it did in countries such as El Salvador. However, the questions raised by Cash and Castro in their case study in El Salvador (2) are relevant to the Indian context, particularly because the issues are embedded in a larger social structure where women's rights and voices are stifled and denied; and also because the authors urge discussion on a very critical issue in healthcare delivery—that of conscientious objection in medicine.

The authors have described a situation where a provider's duty to her government/state clashes with her fiduciary duty to her patient against a background where abortion is criminalised even when the foetus is afflicted with a severe infection such as ZIKV. Abortion laws in India are comparatively liberal[1] (3); the 2014 amendments to the MTP Act have added to its strengths (4). But that does not mean that the Indian state is truly sensitive to women's needs or prioritises their rights. A state—whether El Salvador or India—and the legal mechanisms it embodies are commonly patriarchal, and questions of ethics stem from the larger socio-legal framework, whether we talk of the right to abortion *per se* in El Salvador, or the right to abort beyond 20 weeks in India[2], or other laws pertaining to women's right to their own bodies, such as the right to abort without the spouse's consent, or the right to contraceptives. In this commentary, I address the questions posed by Cash and Castro and examine the larger issues that are thrown up.

What should the doctor recommend?

To recommend is to put forward a suggestion, approve of some process or action. In this case, the doctor's function would not be to recommend anything right away but primarily to ensure that the woman is able to take an informed decision. However, as evident, the extent and scope of the decision being truly informed is rather limiting under the given set of circumstances, and because of these constraints, it becomes all the more important for the provider to offer information and explanation to the woman. The woman needs to understand the implications of giving birth to the foetus, as also the consequences of opting for an abortion in the current legal regime. After thinking through her options and their respective

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consequences, whatever course of action the woman decides to take, with its limitations, needs to be respected as *her* decision.

Should the doctor give the woman a set of choices that include an illegal act, punishable under the law?

The core dilemma in this case arises from the contradiction between El Salvador's laws, which criminalise abortion, and the medical indication for one. Nonetheless, the provider's duty is to explain all options to the woman, including, in this case, those that are illegal; because what is illegal is precisely what the woman not only needs but specifically asks for. This is not to suggest that if a patient wants something that contravenes the law, the doctor should always provide information about it. However, in this case, the premise is that safe abortion is the right of every woman, and there is also a medical indication for terminating the pregnancy. So, when a law obstructs women's access to safe abortion, ignoring the dangers some pregnancies put women and foetuses through, we ought to realise that the law is denying a woman her basic rights.

In this particular case, the conflict is between the oppressive ideologies of the state of El Salvador and a person's right to her own body and health; therefore, in this specific case, the doctor's fiduciary duty should triumph over her duty to abide by the laws of the country. The Citizen Group for the Decriminalization of Therapeutic, Ethical, and Eugenic Abortion (CFDA), of which this physician is a member, will have other members who are human rights activists and advocates, and she should enlist their advice on how best to help the woman get access to safe abortion and legal aid when needed.

One could always ask, "What if the woman gets caught by the authorities? Who bears the responsibility then?" There is no linear or reassuring answer to that, for if the woman were to continue with the pregnancy and give birth to a microcephalic infant with extremely high levels of morbidity, who would bear the responsibility for that? With snowballing and severe consequences at both ends of the spectrum, it is the woman's needs that should be the anchor point for deciding on the nature of action.

What if the patient cannot afford an in-country abortion?

If the patient cannot afford an in-country abortion, the situation becomes far more complex. I sift through the possible routes for the doctor: She could, given the gravity of this situation, enlist the help of one of her colleagues who she knows would be willing to offer safe and confidential abortion to the woman. Alternatively, she could put the woman in touch with networks and organisations that are in a position to raise funds or provide help otherwise. The doctor is a member of the CFDA and believes that the state's anti-abortion policies are oppressive and harmful; when we witness a situation where even miscarriages run the risk of getting identified as abortions leading to incarceration, and where even victims of rape or incest are not allowed to seek abortion, we need to realise that such laws contribute to maternal mortality (5) and are draconian.

As a longer-term measure, even if only until these draconian laws are overwritten, it would be useful to bring together the providers of illegal abortion services and build their capacity to provide their services in a clean and safe manner. This would be similar to how, in India, health activists work with unqualified healthcare providers, especially in tribal and remote areas where state healthcare exists in abysmal conditions or not at all, in order to ensure that the people receive some care rather than none.

In this case, however, the doctor realises the severity of the consequences if the child is born, more so when it is against the woman's wishes. The foetus is afflicted with ZIKV, and if it is not aborted, the woman would undergo severe trauma for the remaining duration of the pregnancy. The infant would be born with microcephaly and either die soon after or suffer extremely high levels of lifelong morbidity. For a working-class couple with three other children, caring for this infant and ensuring a decent standard of care for it would be extremely difficult, if not impossible. All these factors put together make the case an exceptional one meriting exceptional—even if illegal—redressal.

Does the doctor have a duty to her patient that transcends the law of the land?

There cannot be a fixed standpoint on this question; it needs to be examined per case and would be contingent upon several factors. In this specific case, the doctor's duty to the patient happens to transcend the law of the land. Access to safe abortion is a woman's right; besides, it is the duty of a physician to provide it. When the law of the land works to deny this right, the doctor's fiduciary duty should supersede her duties towards the State. When it comes to *how* the doctor would provide the services, further complications arise, some of which I have tried to address above. As to the *duty* of the provider, yes, it should transcend the laws of the land in this specific case. This also opens up the discussion on conscientious objection in medicine, which I address in the following paragraph.

Does it matter what the doctor's personal beliefs on abortion are?

Personal ideologies should not inform ethical practice, though it is practical to admit that for a lot of people they do. In this case too, if the doctor had been morally opposed to abortion and had not believed in women's rights, she might have told the woman there was nothing she could do and highlighted the illegality of abortion. But this should not be the way physicians function; attending to the needs of patients and prioritising their rights should shape medical practice in order to make it just and ethical. So even if a doctor considers abortion to be morally wrong,

s/he should ensure that a woman who requires it has access to safe abortion services. This takes us to a complex juncture within the discourse on conscientious objection in medicine; Cash and Castro throw up a far more complex scenario than the one Savulescu (6) and Schuklenk (7) talk about. Both of them, using different arguments and examples, argue that personal beliefs of doctors should not be allowed to interfere with medical care, something I echo in the first line of this response. Personal ideologies and religious beliefs should not lead to patients receiving differentiated treatments from different providers. According to Savulescu and Schuklenk, when something is provided to one, it should be provided to all. When the law provides a service, no provider should cite personal prejudice and deny it to the patient; in other words, all providers should abide by the law.

Adopting a counter position, Cowley (8) points out the weakness in the arguments of Savulescu and Schuklenk to argue in favour of conscientious objection in medicine. His thesis, however, is mostly a set of counterpoints to the two authors and not a robust philosophical and ethical enunciation of *why* this form of objection should be accommodated within medical practice whether or not people oppose it. In other words, Cowley does not dwell on the merits of conscientious objection in themselves. The premise for all three authors is ultimately the same: when the law allows something, say abortion, does the provider have the right to not offer it because of personal religious beliefs and moral objections? Savulescu and Schuklenk say no; Cowley says yes.

Cash and Castro open up a much more complex scenario: in El Salvador, the question gets turned on its head to become, "When the law specifically criminalises abortion, does the provider have a right to offer it?" What would conscientious objection in medicine mean in such a context? Is *not* offering abortion in El Salvador a display of conscience-based objection? Cash and Castro give an intriguing twist to the discourse on conscientious objection in medicine, as opposing strands from Savulescu and Schuklenk and from Cowley are called to coexist: Personal ideologies should not be allowed to inform ethical medical practice; the provider should do only that which is in the best interest of the patient and conform to the standards of good clinical practice. And it is precisely *because* of this that, in this case, the provider needs to move beyond the dictates of the law, to register her objection to it as it were. However, this objection need not stem from her conscience, but from her sense of good and ethical medical practice.

Does it matter that El Salvador is a democracy and a majority supports highly restrictive abortion laws?

In democracies, such as El Salvador and India, it is assumed that laws are supported by a majority or they would not have been in existence. However, when laws are blatantly regressive—such that they end up incarcerating women for undergoing miscarriages or pushing them even to death by making them seek shoddy abortion services—they need to be challenged and changed. In India, we have laws that criminalise same-sex unions on the one hand and refuse to criminalise marital rape on the other. Whether these laws are supported by the majority in terms of numbers is not the point; the point is that when fairness and justice are at stake, even majorities are liable to challenged. Laws are created to help people, not add to their woes. Laws should not be insurmountable; they are meant to be challenged and rewritten. A social mobilisation need not always be done by the numerical majority; it is the collective will and strength that matters, and smaller groups have brought paradigm changes in the past as well. The centuries-old legal definition of rape was changed in India (in light of the recommendations of the Justice Verma Committee Report, 2013) (9) to become more sensitive to concepts of consent and violations; this did not happen because a "large number" of people asked for it. The Committee itself consisted of three people, and the recommendations were supported by a handful of rights-based organisations. The important factor is the will to change what is repressive.

Does it matter that, according to a recent Pan American Health Organization (PAHO) guidance document, all governments are bound by a duty to provide information, respect the right to choose, and provide access to comprehensive reproductive healthcare and social support to women affected by ZIKV and their children?

While a guidance document is not legally binding, non-adherence should nonetheless count as a serious lapse on the part of a government. It is the moral responsibility of any government to protect the rights of its own people and ensure their liberty and agency over their own lives and bodies. According to PAHO, all governments are duty bound to provide information to the people and respect their right to choose for themselves, provide them access to comprehensive reproductive healthcare, and offer social support to women and children affected by ZIKV. Consequently, when the laws of a country systematically stifle each of these conditions, the legal mechanism itself becomes a threat to the liberty of the people. If the doctor decides to go against the laws of her country, in this case by providing her patient information on abortion services, she would actually be abiding by the fundamentals of bioethics—non-maleficence, beneficence, and justice.

Conclusion

The ZIKV epidemic is facilitated by poor sanitation conditions, low public awareness, and an inadequate political will. The epidemic evidently is a failure of the state mechanisms. For the state to now penalise its citizens for its own failure is unjust and tyrannical. To make citizens shoulder the onus of the limitations and failings of the state makes the latter authoritarian, regressive, and in essence undemocratic. Democracy is not just about the method of electing a government but also about how the state accommodates

the needs of its own people. When a country incentivises and glorifies sterilisations, even when forced and done without the informed consent of the patient (10,11) we are stranded in a grossly undemocratic environment that needs to be questioned and challenged.

This woman in El Salvador, and other women in other countries including India, should have the right to decide when they wish to reproduce and when they might want to terminate their pregnancies for their own reasons. In India, even if the "reason" is not covered by the list drawn up by the state, a woman should be allowed to opt for termination of pregnancy. The deeper underlying question is of bodily integrity and autonomy, which extends to include reproductive agency. There is no mention of the rights of the foetus in any of the international declarations or conventions (12), and such orthodox positions, even when supported by the state and religious dictates, should be challenged. To prioritise the rights of the unborn foetus over the rights and life of a woman is grossly unfair. Such a stance denies a woman her basic right to live with dignity as a human being.

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Notes

[1] In 1971, India passed the Medical Termination of Pregnancy Act, which allowed a woman to access abortion services from registered providers in these conditions: when a pregnancy is within 20 weeks it can be terminated if, in the opinion of two registered medical practitioners, the physical or mental health of the woman is endangered by the pregnancy; if the child could be born with severe mental or physical abnormalities, if the pregnancy is the consequence of rape or contraceptive failure; or with her guardian's consent, if the woman is a minor or of unsound mind. The Bill was amended in 2017 (http://164.100.24.219/BillsTexts/RSBillTexts/AsIntroduced/MTP-4817-E.pdf)

[2] Cases abound in India where the woman was denied abortion even when the pregnancy was the result of incest/rape or the foetus had severe congenital abnormalities merely because the 20-week limit during which Indian law allows abortions had passed. In 2008, Niketa Mehta was denied permission by the Mumbai High Court to abort a 26-week-old foetus with congenital abnormalities (Dr. Nikhil D. Datar vs. Union of India & Ors., [SLP (C) 5334 of 2009]). In 2009, the Supreme Court stayed a High Court of Punjab and Haryana verdict that a mentally unsound woman abort her foetus (consequence of a rape) (Suchita Srivastava & Anr. vs Chandigarh Administration 2009). In 2017, in Alakh Alok Srivastava vs Union of India and Ors (Writ petition Civil No 565/2017) a 10-year-old girl was refused abortion by the Supreme Court of India. The girl had been repeatedly raped by her uncle and as a result had become pregnant, a condition she did not understand until it was past the 20-week period. The court ruled that abortion at such an advanced stage (around 26 weeks) could not be allowed.

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