Beliefs & Practices: Brief Communications from other practitioners

William P. Teubl, M.D., of Rhinebeck, NY, has produced a brief essay on oral contraceptives for personal use, on why he no longer prescribes them. He intends the essay to be readable by non-Christians.

Moral Issues in Oral Contraception

When advising a patient, a physician must communicate the truth accurately and clearly. The physician's and patient's knowledge and preference result in a plan of action. Such a plan must be for the patient's good. A physician must not formulate or endorse a plan that he perceives to be of harm to the patient. A plan that involves risk is acceptable if the potential benefit to the patient outweighs the risk in the mind of both patient and physician.

Birth control may be of benefit to a sexually active couple who are not prepared for a child provided it does not violate their conscience. Abortion can be used as birth control, but it has been condemned because it does harm by taking a human life. Methods of birth control that act partly or entirely as abortifacients represent the same ethical dilemma as more invasive methods of abortion.

The incidence of conception in a woman using oral contraceptives is unknown, but recent data (1) indicates an ovulation rate of 4.7% on the low dose pill. Older literature estimates the rate to be between 2% and 10% (2). The likelihood of implantation given the histological appearance of the endometrium is considered very low (3), therefore the conception rate is essentially the rate of ovulation times the chance of fertilization. For unprotected intercourse the fertilization rate is approximately 20% (4). The effectiveness of cervical mucous changes in preventing fertilization has not been well studied, so sensitivity analysis is needed to estimate the range of possible conceptions. Given the foregoing a woman's chance of conception any given month is approximately 1% (4.7% X 20%), ignoring the role of cervical mucous changes. On oral contraception, a woman has 13 cycles per year. On the average, then, a woman will have one abortion every eight years she uses oral contraception (13 X 8 X 1%). A corollary is that on the average a physician induces one abortion per year for every eight women for whom he prescribes oral contraception. If cervical mucous changes were 90% effective in preventing fertilization, a physician would induce one abortion each year for every eighty women treated.

The statistics above are sobering for any physician or patient who is sensitive to minimizing harm. Even if oral contraception caused only one abortion every ten years in a given practice the moral argument against their use is strong. Using the above figures, if a physician prescribed for 160 women per year, he would cause eighty abortions over a forty year career. If cervical mucous was less than 90% effective, the figure would be higher. It is impossible to predict who would abort when.

Given the foregoing estimates and the availability of effective barrier methods and natural family planning a strong argument against the use of oral contraception can be made. Each physician has an obligation to weigh the perceived benefits to his patient against the harm just described. If as a result a physician's conscience does not permit him to prescribe oral contraception, he is obligated to inform his patients in an accurate, clear, and sensitive manner. Subsequently, he must develop a plan to phase out the use of oral contraceptives. Should a physician's conscience allow him to prescribe oral contraceptives, he is obliged to inform his patients of the abortifacient potential of the drug in question. Not to do so would be a denial of informed consent and would violate the conscience of patients who hold abortion to be morally unjustified.

In conclusion, the following statements appear to be justified:

1. A physician must be truthful with his patient.

2. Oral contraceptives are abortifacients.

3. A physician's conscience may prohibit him from prescribing oral contraceptives.

4. A physician prescribing an oral contraceptive must inform his patients of its abortifacient potential.

The physician who operates under these conclusions with a clear conscience fulfills his obligation to seek the good of his patient.

Endnote

1. Arguments developed are for the low dose pill, since they are most commonly used. The minipill and high dose pill require a somewhat different analysis.

Bibliography

1. Van de Vange, N., Second International Conference of the Society for Advancement in Contraception, Nov. 26 - 30, 1984.

2. Peel, J, and Potts, M., Textbook of Contraceptive Practice, Cambridge University Press, 1969, p. 99.

3. Guttmacher, A. "Prevention of conception through contraception and sterilization," Gynecology and Obstetrics, Carl H. Davis, ed., Vol. 1.

4. Tietze, C., "Differential fecundity and effectiveness of contraception," Eugenics Review, Vol. 50, 1959, p. 231.

Robert S. Jaggard, M.D., independent practitioner of private medicine in Oelwin, Iowa, sends a sample copy of the billing form he uses in his office, incorporating his answer to the intrusion of civil government.

PLACE of SERVICE is at the office unless otherwise specified. TIME listed is approximate number of minutes devoted to this service for this patient by Dr. Jaggard. FEE listed is that amount agreed upon by the patient and Dr. Jaggard as the proper payment for the doctor for this service. No real or implied contract exists between Dr. Jaggard and anybody else but the patient.

DATE TIME SERVICE & DIAGNOSIS FEE

I have NO fee schedule. I use NO "code numbers." I use plain language that the patient understands. I do my best for the individual patient. ALL of my patients are Private Patients. Each private patient pays me the amount that the private patient decides is the proper amount to pay me for this service for this private patient on this occasion. I make suggestions, but the final decision as to the value of my service is up to the individual private patient. The amount of payment is listed in the right-hand column as the FEE. When this is paid, then that item is marked, "Paid," and dated, and that is the receipt.

If patients have private insurance, they can use this statement (or receipt) to submit THEIR claim to THEIR insurance company. Patients understand up front that I have NO contract with any insurance company, and I am not part of THEIR insurance contract, and it is up to the company to pay THEM in accordance with THEIR contract with THEIR company. My ONLY contract is with the patient.

Poor patients who do NOT smoke tobacco or drink alcohol are told that the service is available at "no charge." However, if they have cash for tobacco or alcohol, they have cash with which they can pay me.

Patients who have been trapped in the government tax-paid programs (such as "Medicare" and "Medicaid") are frankly told, up front, that I am NOT part of those political programs, because they do NOT allow the doctor to serve the patient, and they do NOT give the patient or doctor any right to make any choices in regard to treatment. Patients are informed that I will give them medical service at "no charge," but I can NOT help them get any money from "Medicare" or "Medicaid." The big sign hanging in the office front window says, "PRIVATE MEDICINE." There is a sign on my front desk that says, "I am NOT a Government doctor." My policy has been (and still is) well publicized in the local newspaper.

I do NOT have to follow the "Medicare" rules because

I am NOT part of their program, AND, neither are my patients. My service is available to patients at "no charge," so there is no possibility of reimbursement from Medicare (or supplemental insurance), so there is no reason to fill out a claim form. Also, my service is NOT "medically necessary." My service is helpful, and sometimes life-saving, yes, but "medically necessary" is a political term that has no relationship whatsoever to scientific medicine. I have NEVER certified ANY care as being "medically necessary," and Medicare does NOT cover ANY care unless it is "medically necessary." Since there is "no charge," and it is not "necessary," my service is not involved with , and is not part of, the "Medicare" program.

To those patients who have Part B of Title XVIII, I explain that my service is available at No Charge, and, any money they pay me will NOT be reimbursed in any way by "medicare" or their supplemental insurance company. Patients who appreciate my service for them give me money to help pay the office expenses. I help them. They help me. We deal with each other in peace and honesty. We enjoy freedom together.