

# Counseling Women on Long Acting Reversible Contraceptive (LARC) Use While Maintaining Reproductive Justice

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## THE CASE

A 32-year-old G7P5115 (seventh pregnancy, 5 live births) mother at 30-weeks of gestation was admitted with preterm labor for a trial of labor after cesarean section. Her first five deliveries were uncomplicated vaginal births that resulted in healthy babies; however, her sixth was an emergency C-section for preterm premature rupture of membranes and fetal distress. The infant was born premature, and did not survive. For this pregnancy, the patient was not adherent to prenatal care, only attending some prenatal appointments.

The Department of Children, Youth, and Families (DCYF) removed her first child due to concerns of neglect. She elected to give each of her subsequent children to DCYF for placement and planned on giving this child to DCYF as well. The medical student assisted the patient in her labor and delivery room, discussing her current concerns about the delivery and her experience with birth control. She hadn't had "good experiences" with birth control in the past and had no plans for postpartum contraception. When asked if she was interested in preventing future pregnancies, the patient said, "No, I'm not." The student verified that the patient had correct information about birth control options. The patient acknowledged the information, saying that having a baby at this point was "no big deal." Other providers had explained the dangers of multiple pregnancies on her health, the potential negative outcomes for future unborn babies, the hardship of living in the DCYF system, and the ease of various birth control options. The medical student felt a professional obligation to address birth control options with the patient even though the patient was consistent in her lack of interest in starting a birth control method.

## THE ETHICS DILEMMA

Should reproductive health practitioners continue to discuss LARC use to women who repeatedly decline?

## STUDENT ANALYSIS (CG, NN, NN)

This provider-patient interaction highlights the tension between patient autonomy and medical beneficence. The reversibility, widespread access, and insurance coverage of long acting reversible contraceptives (LARCs) make these an attractive solution to prevent unintended pregnancies for women. The American College of Obstetricians and Gynecologists states that women have the "right to safe

childbearing with resources available to reduce maternal and infant morbidity and mortality" in their statement of policy for LARC use.<sup>1</sup> Although some may argue that this stance is paternalistic, the Hippocratic oath gives clinicians the responsibility to offer treatment to patients whenever possible.<sup>2</sup> Multiparity is a well-studied risk that has been linked to increased complications like placenta previa and low Apgar scores.<sup>3,4</sup>

Most would agree that unfettered access to reproductive choices is a worthy goal, perhaps especially for those caring for patients living in poverty. LARCs offer a solution to help break the vicious cycle of poverty by allowing women to exercise sexual autonomy without the financial implications of raising a child. The percentage of children born into low-income families has gradually been increasing in recent years.<sup>5</sup> Children in low-income families are more likely to be premature, have failure to thrive, and to later develop illnesses. This increases psychological, financial, and emotional stress on the family and poses a financial burden for the healthcare and social systems.

Physicians have a responsibility to care for their patients in ways that will benefit those patients long-term and also to consider the effects that those patients have on the healthcare system. Practitioners should help protect the system to ensure optimal care for all. Advocacy for contraceptive use is rooted in the passion to improve patient sexual freedom *and* healthcare costs. LARCs are safe, reversible options that should be presented to patients, especially those at higher social risk for unplanned pregnancies. Encouraging LARC use has significant benefits for both the patient and society as a whole.

However, concerns have been raised about whether efforts to expand access to long-term birth control methods limit the ability of marginalized women to exercise their right to reproduce.

It has been well documented that disenfranchised women have been forcibly sterilized. The Eugenics Board of North Carolina, established in 1933, oversaw the practice of involuntary sterilization of prison inmates and hospitalized psychiatric patients as a tool to combat poverty and welfare costs.<sup>6</sup> Welfare officials petitioned for sterilization of welfare recipients to control rising expenditures. Well-meaning contraceptive advocates during the Progressive era suggested promotion of contraception to control growing immigrant and poor populations.<sup>7</sup>

In the 1990s, a levonorgestrel-releasing implant was

aggressively marketed to poor women and women of color, especially in urban neighborhoods.<sup>8</sup> Several bills were proposed that provided financial incentives to female welfare recipients who agreed to use this method.<sup>9</sup> Judges have offered it as an alternative to jail time for women convicted of drug abuse during pregnancy.

Such coercive approaches are hard to justify. However, due to the convenient reversibility of LARCs, is it permissible to aggressively encourage LARC use for low socioeconomic and young women? A reproductive justice approach would involve the perfect balance between reducing barriers to LARC access, especially amongst those who have poor access to healthcare, while respecting a decision to *not* use these methods.<sup>5</sup> In the patient scenario presented, healthcare providers have a strong obligation to counsel the patient to adopt the use of LARCs because of her pregnancy history and social history, despite the patient repeatedly declining. Health providers should work to improve access to LARCs while respecting patient autonomy. This approach is tested in this case, in which the physician has a hard time convincing a patient that her reproductive choices are, in fact, “a big deal.”

#### ETHICS COMMITTEE ANALYSIS #1 (NA)

This patient has the right to decide whether or not she wants to use birth control. In this scenario, respecting her autonomy has a direct impact on others, namely her children who are now wards of the state. Yet, pushing a conversation on someone who is not willing or ready to listen is fruitless at best and paternalistic at worst. The medical team’s primary responsibility is the patient. There is a conflict between the student’s sense of responsibility to an unborn baby and desire to keep a patient happy through labor and delivery. While medical professionals try to act in the best interest of their patients, many decisions focus on what the doctor thinks is best, with less concern for a patient’s individual circumstances.<sup>10</sup> When the patient’s conception of “best” does not match the medical team’s, the resulting paternalism can be frustrating for all. Respect for autonomy requires that physicians remember that the patient willingly sought care and has the right to make her own decisions. Despite the concerns about the patient’s children, her autonomy with regards to birth control should be respected.

A conversation earlier in the pregnancy might have been tremendously helpful to understanding the patient’s choices, if possible. Contraceptive counseling in clinics has been associated with increased hormonal contraceptive use, and counseling regarding specific types of contraception has been associated with an increase use of those methods.<sup>11</sup> In a more relaxed setting, further questioning into the patient’s circumstances and motivations and a better understanding of her barriers and hesitations might have helped alleviate the frustrations of the medical student.

However, the medical student’s reach is limited to what she can do in the hospital. This much-needed conversation was not going to take place during the patient’s labor and

delivery, which the student likely realized. Similarly, the physicians on the team can only provide help to patients who want it. The best that an inpatient team can do is to meet the patient’s needs at the point of care and send her with as many tools as she can and is willing to carry.

#### ETHICS COMMITTEE ANALYSIS #2 (EM)

Ethical considerations for the medical student include the precarious position as a student observer and the potential to anger the birthing woman to the point of expulsion from the case. There may be a personal agenda from the medical student to prevent future pregnancies, based on sympathy for children who are adopted or living in the foster care system.

Each of these factors present ethical dilemmas and may be adding to moral fatigue for the medical student.

Should the student insist on having a conversation about birth control with the laboring mother? The ethic of respect for persons includes a commitment to the duty-based ethical principle of autonomy.<sup>12</sup> A birthing mother, with capacity, has a negative ethical right to be free of the pressure of listening to education that she does not want, and the health care team should respect this.<sup>13</sup>

However, the mother also has the positive right to competent care from the health care team, which includes education. The principle of fidelity establishes the responsibility of loyalty and trust between the patient and the providers.<sup>14</sup> In this case, there is conflict between the ethical duties to respect autonomy and maintain fidelity. Ranking and balancing the duty-based principles of autonomy and fidelity are best understood within the American cultural context of placing high value on autonomy.<sup>15</sup> Autonomy therefore becomes the prevailing or *prima facie* principle.<sup>16</sup> Additionally, it is unlikely that health promotion or birth control education efforts, during labor, would produce the hoped-for results.

Perhaps another health care team member at another time may be able to build a trusting relationship to advance optimal patient-centered options while providing respectful treatment of birthing mothers, particularly in cases of infant relinquishment.<sup>17</sup>

Finally, the medical student should consider the reexamination of her personal agenda in this case, in which she would like to prevent future pregnancies based on sympathy for children who are adopted or living in the foster care system and the assumption that future children will also be relinquished. The primary obligation must be to the birthing mother and the impact of multiple pregnancies on her physical and emotional health. Perceived prejudice by healthcare providers could negatively impact the health of the birthing mother. There is no definite information here that her previously relinquished children remain in foster care or that they have had difficult life courses. Additionally, there are legal and ethical limits to the scope of interference that can be unilaterally imposed on the birthing mother.

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