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The five-box method: The "four-box method" for the Catholic physician

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Background/Hypothesis: *The traditional ethical model of the "Four-Box Method" can be adapted to integrate the perspective of a Catholic physician. In an increasingly secularist environment, medical students and physicians are often asked to "leave religious beliefs at the door" and not consider the care and stewardship of our own morality and involvement as a provider. We reject this view. A patient's own religious and moral beliefs should be respected to the extent that they do not destroy our own; for us, the Catholic viewpoint can shine a light into dark corners and aid us in translating true things to patients of any religion.*
Methods: *We analyzed a sample case in five different categories: medical indications, patient preferences, quality of life, contextual features, and the Catholic context. We explored how to methodically integrate the perspective of a Catholic physician into the analysis of this case to make the best decision for the patients.*
Results/Discussion: *We felt that we were successfully able to integrate this perspective and create a "fifth box" based on the principles of Catholic social teaching. There were also points during the analysis that the perspective of the Catholic physician was integrated into the discussion of medical indications, proving to us that the "Catholic perspective" cannot be just put in one box either.*

Lay Summary: *The traditional ethical model of the "four-box method" can be adapted to integrate the perspective of a Catholic physician. In an increasingly secularist environment, medical students and physicians are often asked to "leave religious beliefs at the door" and not consider the care and stewardship of our own morality and involvement as a provider. We reject this view. A patient's own religious and moral beliefs should be respected to the extent that they do not destroy our own; for us, the Catholic viewpoint can shine a light into dark corners and aid us in translating true things to patients of any religion. By expanding to a "fifth box" of Catholic social teaching, the Catholic physician finds a way to methodically analyze an ethical scenario. This case study is an example of this type of "five-box" analysis.*

Keywords: Ethics, Pediatrics, Contraception, Religion

Two Adolescents in Twenty Minutes

The following summary is of a case, which occurred in the summer of 2012 at an underserved pediatric clinic in Ohio. Students at Wright State University School of Medicine (Dayton, OH) were asked to analyze the case as the final exam for their course in medical ethics. In this special case analysis for The Linacre Quarterly, *we have provided a Catholic analysis to supplement and enhance the traditional ethical model.*

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The Case

A 15-year-old girl and her 14-year-old cousin present to an underserved clinic with the guardian, who has legal custody of both girls. They are both scheduled in the same room, for 20 minutes total. The "chief complaint" as typed into the electronic medical record by the medical assistant is "need birth control."

The girls were brought to the clinic because the guardian insists that they both receive depot medroxyprogesterone acetate (brand name: Depo-Provera), a reversible, long-acting birth control injection that is given every 3 months.

The 15-year-old has a history of sexual abuse as a child. Subsequently she had 17 previous male sex partners; she is currently in a same-sex relationship and recently has come out to her family. Also, she is in the temporary custody of the maternal aunt, though she visits her father and his girlfriend at their apartment, and spends the night there occasionally. She has a one-year history of very heavy periods.

Her 14-year-old cousin had recently become sexually active with an older teenage boy, who, after having had intercourse with her for her first time, ended the relationship. She has no other relevant medical history.

Both girls refused the Depo-Provera injection. Their objections include (1) possible weight gain; (2) fear of pain from an injection; (3) unnecessary "precaution," neither are currently sexually active or planning to be (they "learned their lesson"); (4) the sexual orientation of the 15-year old makes birth control unnecessary and, she says, an insult to her orientation.

After they are given confidential questionnaires and checked in by the medical assistant, they sneak out of the office and are tracked down by their guardian and made to return to the appointment. They continue to strenuously object to being given Depo-Provera shots against their wishes. Their maturity level was about the norm for their age. They had no attitudinal or cognitive barriers to understanding instructions, answering questions, or being able to balance risks versus benefits.

The guardian confided that she herself was on Depo-Provera for 5 years until she was seventeen and became pregnant with her oldest child. She now lives at home with her husband, 7 children, and her niece. She did not want these girls to "make the same mistakes [she] did."

Introduction

In the initial evaluation of this complex case, we used the four-box method (Jonsen, Siegler, and Winslade 2010, 172–6). This method, which is a case-based, categorical approach to clinical decision making, is meant to help clinicians make ethical decisions by organizing the aspects of the case into the following four categories: relevant medical indications, patient preferences, quality of life, and contextual factors (family, finances, religious beliefs, ethnic background, relationships with care providers, etc.) The four-box method is not a principle-based system, and, in our view, does not help in weighing actual moral principles or in choosing what is right. Rather, the method is an organizing tool, which may allow one to see many crucial details clearly while not over-emphasizing one (e.g., quality of life). Because of this, the four-box method is compatible with both secular and religious methodologies in bioethics.

In this brief analysis, we modified the method to include a fifth box: the Catholic perspective, which we see as surrounding any secular analysis. Ethical analysis, while sometimes revealing truths to us, still needs the Catholic perspective for wholeness. In contrast, in an increasingly secularist environment, as medical

students and physicians we are often asked to "leave religious beliefs at the door" and not consider the care and stewardship of our own morality and involvement as providers. We reject this view. A patient's own religious and moral beliefs should be respected to the extent that they do not destroy our own; for us, the Catholic viewpoint can shine a light into dark corners and aid us in translating true things to patients of any religion.

Medical Indications

The first box in the method enumerates medical indications and medical facts only. One important medical fact is the possibility of pregnancy with high-risk sexual behavior. This includes the guardian's (projected) concern that the girls will become pregnant. The proposed solution to this problem is to give both girls birth control injections and have subsequent follow-up appointments every 3 months. Depo-Provera is considered 99 percent effective in preventing pregnancy when given every 12 weeks with perfect use; however, the typical use effectiveness is 94 percent and it does not protect against sexually transmitted diseases (STDs) (Trussell 2011, 397–404). From a purely medical perspective, this would leave the girls vulnerable to sexually transmitted infection if they rely on Depo-Provera as their only form of birth control. This decision would also be considered a chronic problem since the girls are young; if they were to start birth control immediately they would likely be on it for a very long time. Depo-Provera is also considered a reversible type of birth control, since 13 weeks after injections are stopped, fertility usually returns (Pfizer 2006). But, any hormonal birth control option comes with significant additional risks; side effects may include depression, weight gain, loss of bone density, acne, weakness and fatigue, abdominal pain, and the increased risk of thromboembolic events (Veisi and Zangeneh 2013, 109–13). The severity of these symptoms depends on each individual, but they could all potentially increase morbidity and even mortality. The possibility of long-term use also means that the possible side effects would be more concerning for these young girls. The chance of pregnancy is not an emergent problem, however, since both girls say that they are no longer having sexual intercourse and do not plan to anytime in the near future. Nevertheless, we believe that high-risk sexual behavior is also a medical problem that should be discussed openly and honestly with the family at hand. What does early or frequent sexual behavior do to self-esteem and mental health in teens? Studies suggest there is a medical risk involved (Ma et al. 2009). But the positive aspects of abstinence should also be discussed with the family. For example, small but rigorous studies have shown that abstinence can be effective in at-risk populations who are highly motivated. Both of these girls, for their own reasons and, however, questionable, seem highly motivated. We should look on that aspect of the case as a gift, take them at their word, and try to utilize—not tamp down—that motivation. Finally, pregnancy outside of marriage and its risk to medical well-being should be discussed so that the implications of an unintended pregnancy on all of their lives are clear.

The 15-year-old has a one-year history of very heavy periods, and some doctors will prescribe birth control to eliminate ovulation in the hopes of therapeutic benefit of lighter periods. However, there are other ways to treat very heavy periods such as cyclic progesterone therapy and an extensive evaluation of her cycles to see if there is an underlying condition behind

the heavy periods (Hilgers 2004, 251). Those options should also be discussed with the 15-year-old and her guardian.

From a practical standpoint, there may be significant difficulty getting the girls to get the intramuscular injection every three months (even if one argued it was right) since they are already so resistant, and the 15-year-old is only in the temporary custody of her aunt and guardian. Failure to do so could lead to pregnancy if the girls resume sexual activity.

There is quite a bit of addition information that should be obtained and disseminated. Talking to both of the girls in a positive way about abstinence is a first step. (This conversation can be difficult, and many clinicians are not at ease with this subject.) Then, querying about a plan if they were to have an unintended pregnancy in the future would be crucial. Both girls should also be tested for STDs and have a gynecological exam since they both had been sexually active in the past. We would also talk to the girls about their futures and their plans for education, marriage, and children. We would discuss the importance of communication with both children and their guardian as a family. We are obligated to inquire more about the 15-year-old's heavy periods (in a separate visit) and what kind of symptoms she had before and during her periods and discuss possible alternative treatments with her as well. Her new homosexual orientation also should be discussed at a separate visit; she had 17 (opposite-sex) sexual partners prior to this self-revelation, and it seems that the good clinician would want to pursue this further in care for her mental and sexual health.

Patient Preferences

The next step in the four-box method involves considering patient preferences. In pediatric decision making, current American Academy of Pediatrics guidelines suggest broad autonomy for adolescent decision making about sexual choices (AAP 2007, 1135–48). A full critique of these guidelines is beyond the scope of this analysis. The patients' preferences here seem very clear; both girls do not want to receive the birth control shot and refuse to assent to the injection. Just looking at this, administering an injection to an adolescent patient against her will would most likely have an incredibly detrimental effect on the physician–patient relationship going forward. This should be taken into consideration, as the physician's rapport with the patient is very important to continued care and patient compliance. The girls are worried about gaining weight from Depo-Provera; neither is currently sexually active or planning to be sexually active in the near future; the 15-year-old says that giving her the shot would be an insult to her sexual orientation. This last issue alone is so complex that giving Depo-Provera does not begin to address it appropriately. The patients seem to have been informed of at least some of the benefits but very few of the risks (except for some possible minor side effects of the injection). The physician therefore should go over the mechanism, purpose, and side effects comprehensively so that both the girls and the guardian would be well informed as they consider their options, even if the physician refuses to provide them with this course of action. Even if they leave the office because of this, they have the right to be informed, and to understand precisely why you object. Patient autonomy requires authentic informed consent, which includes a comprehensive discussion of risks and benefits of any treatment.

Both girls seem to be at about the maturity level of their chronological ages. While the guardian has to consent to

treatment for the girls, their assent to treatment should be highly considered. They both have some legitimate concerns about receiving the injection and do not believe "treatment" for a possible future "condition" is necessary. Since, legally, these girls could receive birth control without their guardian's consent under Title X (Maradiegue 2003, 170–77); it also seems reasonable that the girls could refuse birth control even though their guardian wants them to have it. Legal precedence and statute in the US generally concludes that reproductive decisions by minors regarding birth control are considered a confidential matter in which parents or guardians do not have to be involved. For those that support unfettered "reproductive choice," one cannot have it both ways—therefore the minors' right *not to choose* contraceptives should be respected. On the other hand, although the law generally supports adolescent confidentiality if needed, this does not mean that it is the ideal. Parents or guardians should be involved in these decisions and the pediatrician should facilitate this to the greatest extent possible by building trust and working to promote authentic and strong family lives.

Quality of Life

The third part of the four-box method asks clinicians to weigh considerations about the patient's quality of life. Quality-of-life considerations here include the aforementioned possible side effects of the birth control method including weight gain, headaches, depression, increased risk of blood clots, and possible effects of becoming pregnant. One aspect of the quality of life, which would be left out by many of our classmates, is the significant impact that forcing two teenagers against their will to have hormonal birth control would have on their self-esteem. The older girl who claims to have a same-sex attraction now has already indicated that she would be deeply insulted. The younger girl, however, shows signs of possible enlightenment, of growing virtue. She claims she has "learned her lessons" and would like to abstain until marriage. Are we to believe her? The Catholic physician should say, *"Why shouldn't we believe her?"* and then work hard (perhaps extra hard!) to nurture and promote this new attitude. Instead, the secular professional might greet her newfound insight skeptically, even derisively. We feel this skepticism should be strongly resisted, because the quality of life would suffer by negating a teen's positive choices, however difficult.

Of course, it must be said that a possible outcome of not getting Depo-Provera is that if the girls do become sexually active again they would have an increased chance of becoming pregnant. A pregnancy would result in significant changes in their quality of life. Many teen mothers drop out of school, thus hindering future job and educational opportunities. If there is no "significant other" in the picture, the girls would be forced to raise a child by themselves, with possible aid from already strained family members. This puts a significant financial, social, and emotional burden on the rest of the family. It underscores the need both to empower young girls with an abstinence message, and to motivate society to seek social justice for the poor (both economic and relational). The strain of unexpected pregnancies can be lessened by promoting strong families as well.

Contextual Features

The fourth box involves comprehensive consideration of the contextual features of the case. As far as contextual factors go, the

guardian of both girls is very adamant about putting both girls on birth control so that they do not "make the same mistakes she did." She became pregnant with her first child when she was 17 and hopes to put the girls on birth control to avoid that happening to them. Since this case takes place at an underserved clinic, financial considerations could be significant here. It would be important to explore this with the girls and the guardian. There would be long-term significant financial considerations if one or both girls became pregnant as teenagers, too. This should be discussed with both girls when talking about the chances of becoming pregnant if sexual activity were resumed in the future. No religious factors were brought up by either the patients or their guardian. Culturally, it seems that there is a precedent for early (and frequent) sexual activity. This should be discussed with both the guardian and the girls in the context of the 100 percent effectiveness of abstinence in preventing pregnancy. And, if the girls are serious about abstaining from intercourse, there is no reason for them to be on birth control. The girls should realize that although abstinence is difficult, it is absolutely possible and highly effective. This would also be a good time to discuss with the girls and their guardian what their goals are in life. This would be a way to help the girls see that early sexual activity would not be in their best interest for attaining their future goals. The American Academy of Pediatrics recommends abstinence as "the most effective means of birth control and prevention of STIs and is a viable strategy in the clinician's toolkit for reducing unintended pregnancy and achieving reduction in STI rates. Abstinence education generally focuses on delaying the initiation of adolescent sexual activity until marriage" (AAP 2007, 1135–48). The chances of a contact pregnancy—a pregnancy resulting from heterosexual genital activity without vaginal penetration—should also be discussed for full disclosure in the conversation. It would be a good idea to see if either girl has been tested for STDs in the past, and inquire about use and consistency of condom usage with previous sexual partners. Such a question, while clearly not condoning the behavior, can serve to assess risk of contracting STDs, while offering some insight into the discipline the girls have with respect to abstinence, and how seriously they take pregnancy.

The "Fifth Box": The Catholic Context

We have already alluded to many aspects of Catholic moral thought in the preceding paragraphs that might distinguish the approach of the Catholic medical student or physician, including abstinence education as the principal strategy for reducing the chance of pregnancy and building strong self-esteem and ultimately strong families; inclusion of the family (rather than exclusion) as the default in discussions about sexual health in teens; and social justice and family-building to help alleviate economic pressures of unexpected birth among the poor. All of these efforts take (probably financially uncompensated) time. This is part of the sacrifice the Catholic physician commits herself to.

More specifically, Roman Catholic teaching against contraceptives was upheld and explained in Pope Paul VI's encyclical *Humanae vitae* in 1968. A portion of this document specifically addressed to physicians who are asked to prescribe contraceptives:

> Likewise we hold in the highest esteem those doctors and members of the nursing profession who, in the exercise of their calling, endeavor to fulfill the demands of their Christian vocation

> before any merely human interest. Let them therefore continue constant in their resolution always to support those lines of action which accord with faith and with right reason… Moreover, they should regard it as an essential part of their skill to make themselves fully proficient in this difficult field of medical knowledge. (Pope Paul VI 1968)

Catholic social teaching also supports the basic teaching of *Humanae vitae*. The central theme of life and dignity of the human person (USCCB 1998) is especially important when taking into account the evidence that one of the mechanisms by which hormonal contraceptives like Depo-Provera work is the making of the lining of the uterus inhospitable to a fertilized egg thereby causing an early abortion if a breakthrough ovulation was to occur. Chemical abortion, of course, is contrary to Catholic social teaching.

In addition, the recurrent theme of Catholic social teaching of the option for the poor and vulnerable (USCCB 1998) applies here. The teen girls who are coming into the clinic are obviously very vulnerable and are coming from a poor background as well. The aunt/guardian of the girls is very concerned that having a child as a teenager would endanger the girls' futures. Since no hormonal birth control method is 100 percent effective, the Depo-Provera shot would not necessarily prevent pregnancy for the girls if they resumed sexual activity. The only 100 percent effective way of preventing pregnancy is abstinence, and this is worth a conversation with both girls and their mother. The American Academy of Pediatrics recommends abstinence as the best way of preventing pregnancy and a Catholic physician especially should be looking at abstinence education as more than this —a treatment plan for the whole dignified person, one which would put these girls in the best possible situation moving forward physically, mentally, and spiritually.

Conclusion

The two major options here are to give both girls Depo-Provera against their wishes, or to not give the shot to either. Ethically, the 14- and 15-year olds, with maturity levels appropriate for their ages, should not be given treatment they adamantly resist. We would not give Depo-Provera to the girls, but instead sit down with all of them (guardian included) to discuss the future. The girls are asking to be treated as adolescents who should be allowed to give assent to any treatment. Reproductive decisions, including sexual activity, are adult decisions with adult consequences, and the girls need to understand the consequences and be able to talk about them with someone they trust. We would look to stress the importance of taking responsibility for sexual activity and making sure both girls know that if either of them were to become sexually active in the future, either on birth control or not, there could be unintended consequences such as STDs or pregnancy; worse, as they have both already experienced, there would certainly be consequences to their self-esteem and well-being as persons. This conversation would include developing a plan of action should they want to consider becoming sexually active again, including our own availability to talk to them if the guardian permits and they feel comfortable. In this way, the Catholic physician herself can be a "therapeutic instrument," more powerful than any surgeon's scalpel.

Although they are minors and cannot legally consent to treatment in most cases, they are still persons with dignity and must assent to treatment. They both have legitimate concerns and are mature enough to be involved in the decision without their

own preferences being completely disregarded. Giving the girls the injection against their wishes would not only make future compliance with injection appointments extremely difficult, it would destroy the development of a strong patient–physician relationship in the long term.

Considering that avoiding unintended pregnancy is a long-term goal articulated by the guardian, it would also be important to talk to her about how it would be more effective to not force the girls into treatment they do not consent to, leaving them with a fear and distrust of medicine, and unlikely to seek medical help in the future. We would want these girls to know that they can talk to their physician about anything, and that their physician will be an advocate for them and for what is best for them. The girls should be encouraged to pursue the path that is in their holistic best interest first and foremost, keeping in mind that the person includes more than biological parts. This is where the Catholic insight is so crucial. Building trust and respect with the girls and their guardian is very important here, and not merely as a strategy for achieving one's goals (although it is that too). Building trust and respecting them as whole persons—insisting on what is right for them even if they do not always see it at first—is showing love as Christ himself did.

Epilogue

In this particular case, the non-Catholic pediatrician, with medical student in tow, continued to forcefully insist that the girls receive the Depo-Provera injection. After fifteen minutes of intense "brow-beating" (verbal coercion), the girls gave in and received the injection. The pediatrician bragged to her medical student: "See, that's how you get things done in 20 minutes."

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