**When fiduciary duty clashes with duty towards the state:**

**Responding to Cash & Castro**

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Despite the reporting of a few cases of Zika in India (1), ZIKV did not turn into an epidemic the way it did in countries such as El Salvador. But the questions raised by Cash and Castro (2) relate 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. The authors have described a situation where a provider’s duty towards her government/state clashes with her fiduciary duty towards her patient against a background where abortion is criminalised, even when the foetus is infected with a severe infection such as ZIKV. Abortion laws in India are comparatively liberal (3), but that does not mean that the Indian state has gone the whole nine yards to become truly sensitive to women’s needs and attend to 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 frame at work, whether we talk of the right to abortion *per se* in El Salvador or the right to abort beyond 20 weeks in India or other laws that implicate women’s right to their own bodies. In this comment I address the questions posed by Cash and Castro, and examine the larger issues that are at stake.

*What should the doctor recommend?*

To recommend is to put forward a suggestion, to approve of something, and in this case the doctor’s prerogative would not be to recommend anything right away, but to first ensure that the woman is able to take an informed decision on her own. Accordingly, the doctor needs to explain to the woman all possible consequences, clinical, social and legal, of continuing with the pregnancy and of aborting the foetus. The doctor should make sure that the woman is able to take her own decision armed with all required information and knowledge.

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

The core dilemma arises from the contradiction between El Salvador’s laws which criminalise abortion and the pregnant woman’s need for one. Nonetheless, it is the duty of the doctor to explain all options to the woman including, in this case, those that are illegal, because what is illegal is precisely what the woman seeks to have. This is not to suggest that if a patient desires something that contravenes the law, the doctor should, by default, always provide information on that, but in this case the premise is that safe abortion is the right of every woman. When a law, instead of facilitating, prevents it, we ought to realise that the law is truncating a woman’s 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; against this frame and in this specific case, the doctor’s fiduciary duty should triumph over her duty to unquestioningly abide by the laws of the country.

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

However, if the doctor realises that 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 the 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; by putting innocent women behind bars, these laws contribute to maternal mortality. The doctor realises the severity of the consequences if the child is born, more so when against the woman’s wishes. The foetus is affected with ZIKV and if 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 be saddled with extremely high levels of morbidity. For a working class couple with three other children, to take care of this infant and ensure a decent standard of care for it would be extremely difficult, if not impossible. All these put together, makes 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; this needs to be examined case wise 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. Since access to safe abortion is a woman’s right, when the law of the land works to deny this to her, the doctor’s fiduciary duty should supersede her own moral duties as a law-abiding citizen.

*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, it does. 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 now and highlighted the illegality of abortion. But this should not be how doctors work: attending to the needs of patients and prioritising their rights should shape 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 service. However, I add that it does help when a doctor’s own beliefs map on to the ethical course of action; it surely strengthens the cause and better ensures that the woman regains autonomy over her body.

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

In a democracy, such as El Salvador and India, it is assumed that laws are supported by a majority – else they would not have been there. But when laws are blatantly regressive – such that they end up incarcerating women for undergoing miscarriages, or push them even to death by making them seek shoddy abortion services – they need to be challenged and changed. In India we have laws that criminalize same-sex unions on the one hand and refuse to criminalize marital rape on the other. Whether these laws are supported by the majority in terms of empirical 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, they should not be insurmountable; laws are meant to be challenged, changed and rewritten. A social mobilisation need not be always be done by the majority; it is the collective will and strength that matters, and smaller groups have brought paradigm changes in the past as well. That a century old legal definition of ‘rape’ was changed in India (in light of the recommendations of the Justice Verma Committee Report, 2013) to become more sensitive to concepts of consent and violations, 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 question 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 health care 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 health care and offer social support to women and children affected by the ZIKV. Consequently, when the laws of a country systematically stifle each of these conditions, the legal mechanism itself becomes a threat to 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, viz. 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. So now for the state to penalise its citizen 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 actually undemocratic. Democracy is not just about the method of electing a government, but more 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 people (4, 5) we are stranded in a grossly undemocratic ambience which 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 the pregnancies for their own reasons: in India, even if the ‘reason’ is not covered by those categorised by the state (3) a woman should be allowed to opt for termination1. 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 (6, p 181), and such orthodox positions, even when supported by the state and religions, should be challenged. To prioritise the rights of the unborn foetus over the rights and even the life of a woman is grossly unfair and denies her the basic right to live with the dignity of a human being.

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**Notes**

1. Cases abound in India where the woman was denied abortion even when the pregnancy was the result of incest/rape or had severe congenital abnormalities, merely because the 20-week period had passed. In 2008 Nikita Mehta was denied permission by the Mumbai High Court to abort a 26-week-old foetus with congenital abnormalities. In 2009 the Supreme Court challenged the High Court of Punjab and Haryana’s verdict to a mentally unsound woman to abort her foetus (consequence of a rape); in 2017, a 10-year-old girl was refused abortion.

**References**

1. WHO, 2017. Zika virus infection – India. Disease Outbreak News. May 26. <http://www.who.int/csr/don/26-may-2017-zika-ind/en/>
2. Cash, R. and Castro, M. Advising a Woman with Suspected Zika Virus Infection: \*\*\*\*\*\*\*\*\*
3. In 1971 India passed the Medical Termination of Pregnancy Act which allowed a woman to access abortion services from registered providers under five categories of reasons: a pregnancy which is within 20 weeks of age, can be terminated if the health of the woman is endangered by the pregnancy, the child could be born with severe congenital defects, the pregnancy is the consequence of a rape or contraceptive failure, or the woman is a minor or with unsound mental health. (<http://tcw.nic.in/Acts/MTP-Act-1971.pdf>)
4. Biswas, S. 2014. India’s dark history of sterilisation. BBC News. <http://www.bbc.com/news/world-asia-india-30040790>
5. Srinivasan, S. 2016. Why hundreds of women have died in the government’s horrific sterilisation camps. Scroll.in. Feb 5th. <https://scroll.in/pulse/816587/why-hundreds-of-women-have-died-in-the-governments-horrific-sterilisation-camps>.
6. Johari V, Jadhav U. Abortion rights judgment: a ray of hope! *Indian J Med Ethics*. 2017 Jul-Sep;2(3)NS:180-3. DOI: 10.20529/IJME.2017.044.