Who Is The Geneticist’s Patient?

(Fourth of a Series)

CASE: Mrs. G., a twenty-seven-year-old mother of two daughters comes to a geneticist for counseling. There is a history of hemophilia in her family, and she is worried about the possibility of giving birth to an affected male child. She wishes to have tests performed that will determine the sex of the fetus. She indicates her plans to seek an abortion should the tests indicate that she is carrying a male. The geneticist is himself morally opposed to abortion and is uncertain about how responsibilities to the woman may be discharged in such a way that the value of the unborn human life receives due respect.

ALTERNATIVE RESPONSES: One. The counselor's primary responsibility in this case is to the woman, since it is she who has come to him for assistance. By advertising himself as a geneticist, the counselor has entered into an implicit agreement with his client to provide her with medical care and advice to the very best of his ability. Therefore, professional responsibilities are paramount, and the geneticist's own personal moral views should not be a factor in the counseling context. Although this position is commonly espoused by genetic counselors, it should be unacceptable to the Christian. In the first discussion in this series ("The Counselor's Dilemma," Ethics and Medics, July/August, 1977), we noted the Church's insistence that professional and scientific expertise must be integrated with and subordinated to spiritual and religious values ("The Church in the Modern World," para. 43). One might add that the counselor has a professional responsibility to take steps to help prevent his profession from becoming an association of mechanics.

Two. The counselor should explain to the woman that he considers both herself and her unborn child to be his patients and that he will refuse to provide information relating to the detection of untreatable birth defects. This decision to withhold particular forms of information preserves the geneticist's moral integrity and expresses a respect for the welfare of the unborn, but it involves the serious drawback of hindering the development of an open, frank, and trusting relationship between counselor and patient.

Three. The counselor should explain to the woman that, because of his personal opposition to abortion, he will not accept as his patient anyone who might consider seeking an abortion. If the woman should agree to become his patient under those terms, then abortion would be foreclosed, and tests would be undertaken only for treatable conditions or to relieve the anxiety of the mother. Perhaps the single most important objection to this response is that it would limit the influence of counselors opposed to abortion to those who are already in agreement with their views. It would preclude the counselor's exerting moral influence or direction on women who accept abortion as morally justified.

Four. In consideration of the first three alternatives, the preferable response seems to be one in which the counselor: (1) indicates to his patient his moral views on abortion and other matters; (2) promises disclosure of all information relevant to the determination and treatment of birth defects and the alternatives available at each stage; and (3) while respecting the moral autonomy of the woman, gently attempts to dissuade her from seeking an abortion. This approach preserves the integrity of the counselor and permits him to integrate his professional and moral life in such a way that his special expertise is placed at the service of his ethical convictions. Such a response by the genetic counselor, if fashioned in a sensitive and proper manner, is consistent with a respect for the moral integrity of the patient. The fact that sometimes moral influence may appear as dogmatic (Continued on Page Four)