

Medical Humanities Report

Winter, 1994

Contraception and Coercion

By Judith Andre, Ph.D.

The new long-term contraceptives, Norplant implants and depo-provera injections, have been hailed as liberators. But they are also turning out, in some cases, to be occasions for bondage.

These contraceptives do liberate. Women who receive an injection of depo provera will be protected against pregnancy for three months, free of the worry, uncertainty, and inconvenience accompanying older means of contraception. Women who have the matchstick-sized Norplant rods inserted in their arms have five years of such freedom.

But the two means of birth control are also threatening. For each provides, for the first time since chastity belts, a means short of imprisonment or sterilization to keep a woman from getting pregnant. Judges, parole offices, and welfare workers find this new opportunity tempting.

The most dramatic examples have occurred in court. Darlene Johnson, pregnant with her fifth child, was convicted of beating two of her children with a rope and an electric cord. Judge Howard Broadman gave her a choice: prison for several years, or probation--on the condition that she obtain contraceptive implants. This is "creative sentencing," and it's hard not to sympathize with the judge. But a closer look both at the facts of this case and its implications should give anyone pause.

To begin with, the case placed health care

professionals under ethical stress. Ms. Johnson had a heart murmur, diabetes, and hypertension; the hormones implanted could have been dangerous for her. So the judge left the issue up to doctors: is she a medically suitable candidate? Although doctors making such a determination would be to some extent acting to protect the woman they examine, they would fundamentally be serving the interests of the state. Still, company physicians, team doctors, and primary care providers who serve as gatekeepers deal with similar conflicts. Candor about the purpose of the examination probably resolves that difficulty.

Actually implanting the device, however, under these conditions, presents a considerably greater problem for professional integrity. Doctors doing so would act as agents of the state. Although they would be protecting their patients from injury and harm, they would be altering the way someone's body functions because the government wants it altered. This is not a treatment she has chosen.

At least not freely chosen. She had a single, highly unpleasant alternative: to go to prison. There are interesting and philosophically deep issues about freedom and coercion -- for instance, Ms. Johnson seems to be better off with at least this alternative, rather than with no choice at all. Does it still make sense to say she's being coerced?

Since there is no clear, uncontroversial answer to that question, perhaps we should try

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Coercion (cont.)

to formulate a more useful one. Rather than ask whether Ms. Johnson's sentence was coercive, let's ask whether the state should have the power to make such "offers." Possibly the choice given was an "unconstitutional condition": one which the state may not impose because it violates or burdens the exercise of constitutional rights. Even though imprisonment is in some ways a

harsher punishment, "the U.S. Supreme Court long ago rejected the idea that if government can incarcerate you, it can release you on whatever conditions it wishes. . . . Some conditions tread on constitutional values to such a degree that they cannot validly be imposed or consented to. 'Unconstitutional conditions doctrine

protects . . . [citizens against] governmental end-runs.'" Courts may not, for instance, suspend your sentence on the condition that you renounce your religion -- even if your religion means little to you and you would welcome the option. Freedom of religion is a constitutional right. Similarly, there is good reason to think that the constitutional right to privacy includes bodily integrity, and therefore that the implant condition would be unconstitutional. Such a question could only be settled, in the end, by an appeal to the Supreme Court. (Ms. Johnson's case was eventually declared moot by an appellate court, when she violated other conditions of her parole and was sent to prison as a consequence.)

But even constitutional rights may be limited to some extent by the state. Freedom of speech, for instance, does not include the freedom to libel someone, and laws forbidding it are constitutional. When a constitutional right is at stake, however, actions of the state must pass stringent tests. Such actions must be the least restrictive way to prevent serious harm to others,

rationally related to that harm, and imposed without discrimination. Contraceptive implants fail all of these tests. Their use will not prevent further abuse to Ms. Johnson's children; although it will prevent further children being born, giving birth is neither a crime nor an injury to the one born. Furthermore contraception is famously discriminatory: most of the research is

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done on women, most of the technology available is for women, and most of the responsibility for using it rests, socially, with women. Finally implantation is arguably not the least restrictive way even to prevent harm to future children, since (1) even abused children do not, usually, consider their very existence a misfortune, and (2) educating the parent or removing the child is less intrusive. (Parents may hold that removing a child is more intrusive than forced contraception, but constitutionally speaking it would be less so, since bodily integrity is such a serious boundary to breach.)²

Most commentators, then, find Judge Broadman's ruling unconstitutional, and undesirable on ethical grounds as well.

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Editor: R.L. Jackson, M.A.
Center Director: H. Brody, M.D., Ph.D.

A less dramatic but far more common form of coercion concerns removal of the implants, which is expensive and often not covered by government programs or by private insurance (unless there are medical reasons to take them out).³ The contraceptive rods can cause depression, acne, weight gain and irregular bleeding. But the woman without money who wants them removed may be helpless. Critics suggest several remedies, the simplest of which is to be sure patients know in advance what these side effects can be. Women who receive such counseling are far less likely to want them removed. Nevertheless removal needs to be provided for. Insurance (private or state) should either guarantee that removal will be covered when they pay for implantation or include the cost of removal in the initial fee. Even under such a policy life may not be easy. Some clinics require counseling before removal, which is probably a reasonable requirement but is also a step onto a slippery slope. The counseling may become a kind of hearing: prove to me that your reasons are good; persuade me that you will use other contraception reliably. The desire to help a woman think through the issue may easily be contaminated by the desire to prevent another child's being born to the welfare rolls. The second desire is understandable and, strictly as a desire, laudable; but as policy it is invasive. A woman's body is not a zone to be occupied for the purposes of the state. Imagine the furor if such tampering were imposed upon men.

The story of a young woman I'll call Jessica is cautionary. A graduate student at a major university, Jessica has a young son, born before she was twenty. A few years later she received contraceptive implants, paid for by Medicaid. (Graduate students make very little money.) She found herself miserable within a few months, but in her state Medicaid does not pay for removal. She called a number of doctors

and clinics to find out how much removal would cost and couldn't get an answer. (Removal is a new procedure; not everyone has learned how to do it, and it is not yet listed in some schedules of fees; furthermore removal is somewhat tricky, and one doctor told me he was reluctant to perform it on a patient with whom he had no prior relationship, for fear of lawsuit.) A public clinic said they would do the removal, but required counseling first. She found the clinic constantly adversarial: even after the counseling, when she called to schedule the removal she was met with "You'll have to have counseling," and then with "Are you sure?" "What's your reason?" and "What are you going to use instead?" -- questions she had answered many times by then.

Jessica's discomfort, at first simply physical, broadened into pervasive misery as she dealt with months of patronizing resistance. Her body is her own, and reclaiming it should not have been such an ordeal. The new long term contraceptives have opened a door for state coercion, a door that needs to be closed and guarded.

NOTES

¹Michael H. Shapiro, "Was the Norplant Ruling Unconstitutional?", The Los Angeles Daily Journal, February 20, 1992, p. 7, col. 1. Internal quotation is from Sullivan, "Unconstitutional conditions," 102 Harvard Law Review 1413, 1492 (1989)

²My argument here draws from Shapiro (n.1) and from Lenore Kuo, "Coerced Birth Control, Individual Rights, and Discrimination," Biomedical Ethics Reviews, 1992, pp. 101ff.

³Some of my examples and arguments come from Contraceptive Technology Update, Vol. 14, No. 10 (October 1993) pp. 149ff.

Intensive Ethics Workshop

This summer the 4th Annual Intensive Ethics Workshop will be held on the Michigan State campus in East Lansing, from June 18-24.

As in prior years, this year's offering will focus on helping participants develop skills for clinical ethics problem-solving. Although the workshop will feature several major talks (again this year by Tom Murray) and a number of "mini-lectures", most of the hours will be spent in small group sessions. These will be led by faculty from the Center for Ethics and Humanities in the Life Sciences and other experienced members of the Medical Ethics Resource Network of Michigan. These discussions cover issues across a wide range of ethical problems, including questions of competency and treatment refusals, informed consent, HIV testing and confidentiality, limitations of treatment for incompetent patients, the use of advance directives, and others. Through discussion, role-playing, and the give-and-take of reasoned and respectful disagreement, workshop participants have the opportunity to deepen their skills in articulating the complexities of real-life ethical problems, and in working toward resolutions of them in reasoned dialogue with patients, families, and colleagues.

For this reason, the workshop has been especially useful for members of institutional ethics committees, or for those who hope to get one started at their hospital or nursing home. In addition to physicians and nurses, the workshop attracts hospital administrators, risk managers, social workers, and attorneys. Ethics faculty from other colleges and universities also attend as a way of refreshing their own skills and developing different approaches to teaching. Although most participants are from Michigan and surrounding states, there are almost always visitors from farther away— as with the Japanese physician who attended last year. This mix of perspectives, experience and knowledge simulates the structure of a good ethics committee and makes for invigorating conversation. Participants frequently form friendships and professional ties which develop into a long-lasting resource for further collaboration on clinical ethics cases and policies.

Registration information will be published shortly. If you are interested in receiving a brochure and registration packet, please write the Center or call Jan Holmes at (517) 355-7550.

Trust and Medicine

By Rodger L. Jackson, M.A.

“Trust me.”

What does it mean when someone says this to us? What do we mean when we say it to others? Roughly, probably this: believe that I mean you no ill and that you may, without danger, empower me to care for something which is important to you. The fashionably cynical response is to ask what the person really wants while simultaneously putting your hand over your wallet. However, if you stop and consider for a moment the numerous ways in which you trust people every day you begin to see how important trust is to leading a normal life. You trust the day care provider with your children, your spouse with your love, your accountant with your finances, your physician with your health and so on. As even this cursory list indicates, much of what you care most about in the world has to be entrusted to others at times in order to ensure its protection and flourishing. It would be possible to always distrust others, to constantly check up on the people caring for your possessions, to devise schemes whereby you can furtively test whether or not they're fulfilling their assigned task, but think how difficult, joyless and stressful such a life would be. Notice also that for the most part all these and the countless other instances of trust you engage in are successful and fruitful and only in a relatively small number of situations turn out badly.

Trust exists in the context of a relationship and clearly some relationships require more trust than others. The same holds true for trust's counterpart, distrust. We don't trust strangers as much as we do lovers, we don't trust our appliance serviceman as much as we do our lawyer. Partly this is a function of the importance of what it is that is being entrusted to the other and partly this is a function of what we can reasonably expect of one kind of relationship over another. One of the areas of our lives where trust plays an extremely important role is in medicine. Unfortunately, there is not a very extensive body of serious philosophical literature on the role of

trust in medicine. There are numerous articles on how to gain trust from patients, but after reading between the lines these frequently turn out to be articles about how to secure patient compliance. What I would like to do for the remainder of this article is sketch out two issues in which trust or distrust plays a significant role in medicine.

One more point should be noted, that distrust can be divided in many instances into one of two kinds: either a distrust of the competence of person to perform the necessary duty (e.g. you don't think that the surgeon is skilled enough to be able to safely carry out the operation, even though he means you well) or a distrust of the motivations of the one entrusted with the task (e.g. you believe the physician bears you ill will and therefore doesn't do a proper diagnosis, even though he could if he so desired).

AFRICAN AMERICANS AND TRUST

It is a widely documented fact that African Americans are less likely to draw up living wills or to sign organ donation cards than Caucasians. As Marian Secundy pointed out in an article last year in the *Medical Humanities Review*, African Americans are concerned that if they do so physicians will not be as aggressive in treating them when they have serious diseases, possibly even terminating treatment which otherwise would have been continued.

This raises a whole series of difficult and complex questions. For instance, is this distrust based on a belief that it is prejudice or bigotry which would be motivating a physician to back off or cease treatment? Do African Americans believe that because most doctors are Caucasian they will treat African Americans worse than their Caucasian counterparts? Is the distrust they feel targeted towards their personal physician or is it a general distrust of the medical system? Is this distrust warranted? Have there been any studies which can demonstrate that racism figures into such treatment decisions or which can establish that racism doesn't play a significant role in these situations? To the extent that

Trust (cont.)

distrust is warranted, what should be done in order to eliminate the conditions responsible for it and to the extent that the distrust is baseless what steps could be taken to reduce it?

Furthermore, this is only one aspect of the distrust issue regarding African Americans and the medical community. A large number of African Americans believe that the HIV virus was created by the government (being used as part of a secret policy of genocide. A number of African Americans also believe that there is a wide spread policy on the part of the government to sterilize them with the ultimate goal of drastically reducing their overall population (for an excellent discussion of this see Patricia Turner's book, I Heard it Through the Grapevine). While the medical community is not seen as the architects of these programs they are viewed as the mechanics, the instruments of these policies. What should be the medical community's response to these fears? Is it the type of concern that can be alleviated by altering how health care providers interact with their African American patients?

Clearly there is a distrust on the part of African Americans and as a result of this distrust there are a number of unfortunate consequences. Living wills are meant to extend more control to a patient over their health care rather than less and so by not availing themselves to these opportunities where appropriate African Americans may not get the kind of care they truly desire. By not signing donor cards the supply of available organs cannot expand and those who are in need must continue waiting, possibly never receiving a vital transplant. Finally, the intense distrust African Americans feel may cause them to avoid seeking care unless they feel that their illness is intolerable and so to endure much needless pain and suffering.

TRUST BETWEEN NURSES AND PHYSICIANS

The difficulties, tensions and misunderstandings which crop up between nurses and physicians are legion. How much of these difficulties are attributable to problems related to trust? Simply teaching medical ethics to a class of

working nurses provides one with some feel for the variety and depth of the mistrust which nurses feel for doctors. Several of the nurses had a substantial distrust both of the motivations and competency of doctors they have worked for. Many of the doctors they complained about were more concerned with fees than with their patients and not up to date on medical procedures such as pain control.

Is there a corresponding distrust on the part of physicians for nurses? At the Interim meeting of the AMA in New Orleans this winter the delegates backed a toughly worded report which challenged the quest by nurses to become independent primary care providers. In part it said, "Nurses' education does not prepare them to serve as the first point of contact for all the patient's medical and health care needs." (American Medical News, January 17, 1994) This would seem to indicate that when it comes to operating independently of their oversight many physicians do not trust the medical skills of the nursing community.

However, when I posed this question to some nurses they felt that the problem was not that the doctors didn't trust their skills. If a doctor were to walk into an unfamiliar ICU setting it would be quite normal for him to defer to an experienced ICU nurse on some treatment decision. They felt that this was good evidence that the public statements issued by the AMA were not representing the true situation and that doctors felt that most nurses were highly competent. When it comes to setting up their own clinics and possibly depriving doctors of control over the structure of medical practice the AMA is highly resistant because this would rob physicians of enormous psychological and financial power. The nurses I spoke to argued that as far as the way doctors perceived nurses it was not a question of trust or distrust at all, but rather one of money and prestige.

As before a whole set of questions arise from this examination of the status of trust in the medical community. Clearly physicians do wish to retain power over the structure of primary care delivery systems, but the question is whether

or not they have good reasons for their position. After all, to distrust someone is not necessarily a bad thing. If nurses are, in fact, not competent to be able to run their own clinics then the distrust by the AMA is well founded and all to the good. So a number of issues need resolving. Is the analysis by the nurses correct? Do they have good grounds for believing that the AMA's position is not a case of distrust at all? Or are the nurses unfairly judging the physicians and if so what is the source of these erroneous perceptions? Are they due to a lack of proper communication between the two professions? Is it a result of the education process each profession goes through? Is this distrust the result of different ways of viewing medical practice?

Once again a number of problems are the natural consequence of this distrusting. Where doctors and nurses trust and feel comfortable working with each other the quality of care is likely to be significantly higher than in those situations where distrust is the norm. Furthermore, by not allowing

nurses to set up their own practices the AMA is restricting the public's choice of health care delivery systems.

CONCLUSION

As this brief examination has hopefully demonstrated there is a great deal of work to be done in examining the role of trust and medicine. In addition to the two topics addressed above equally important questions need to be examined regarding the proper role of trust in physician/patient relationships, trust between citizens and their government about health care reform, trust between hospital administrators and their staff, trust between specialists and primary care providers, and so on. Sociologists, psychologists, philosophers, bio-ethicists, administrators all have something to contribute to the discussion and all of us, health care providers and patients alike, stand to benefit.

Announcements

As of Fall term Tom Tomlinson will be assuming the position of director of IPHH for a three year term. Professor Tomlinson is assistant director of the Center for Ethics and Humanities in the Life Sciences, as well as associate professor in the Department of Philosophy. Peter Vinten-Johansen, who has been the director since 1987, will be returning to his position in the History Department, although he will remain as part of the core faculty for the Center for Ethics and Humanities. He will be on leave in 1994-95 hoping to complete his "confounded monographs."

The office of Interdisciplinary Programs in Health and Humanities coordinates curriculum issues related to the medical humanities taught in the core colleges at MSU. The program has three primary undertakings.

The M.A. program operates on the premise that bioethical decision-making, cross-cultural medical care delivery and the evolving demands on health care providers are among today's health issues which transcend the boundaries of academic disciplines. In order to understand the complexity of these problems and respond to them wisely, students

require a range of training—both within and across disciplines. The Master of Arts with a major in Health and Humanities is designed to meet this need.

The other two of the IPHH's primary undertakings are the "Specialization in Health and Humanities," designed to complement the academic majors of undergraduate students; and the overseas study programs. This year marks the first year of the summer program in Oslo Norway, "Health Care in a Welfare State: Medical Ethics and Health Care Policy in Norway". The Oslo program will run from July 5-August 8 and be taught by Reidar Lie and Peter Vinten-Johansen. In addition to the Oslo program IPHH will be offering the "Medical Ethics and History of Health Care in London" program which is now entering its ninth year. Anyone interested in information about either overseas program may contact the Office of Overseas Study, 108 International Center, MSU, East Lansing, MI 48824-1035 or telephone: (517) 353-8920.

Coming Events

The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.

Wednesday March 9, 7:30 pm: Thomas R. Cole, Ph.D., Pulitzer nominee for The Journey of Life: A Cultural History of Aging in America will speak at Sparrow Hospital Auditorium. \$5 registration fee. For further information call Hazel Dunnigan

Thursday March 17, noon: Dedria Humphries Barker, Editor-in-Chief of Take Care, new multicultural consumer health magazine, will speak in A211 Life Sciences. For further information contact the Center

Thursday March 24, noon: Sharon Ransom will discuss an ongoing study comparing perceptions of hormone replacment therapy on the part of African American nurses and of white nurses. She will speak in A107-A111 Life Sciences. For further information contact the Center.

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