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ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Unethical female stereotyping in reproductive health

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ABSTRACT

Stereotypes are generalized preconceptions defining individuals by group categories into which they are placed. Women have become stereotyped as homemakers and mothers, with the negative effect of precluding them from other roles and functions. Legislation and judicial constructions show a history, and often a continuing practice, of confining women to these stereotypical functions. In access to reproductive and sexual health care, for instance, women's requests have been professionally subject to approval of their husbands, fathers or comparable males. Choice of abortion is particularly significant, because it embeds moral values. Women's capacity to act as responsible moral agents is denied by stereotypical attitudes shown by legislators, judges, heads of religious denominations, and healthcare providers who consider women incapable of exercising responsible moral choice. These attitudes violate ethical requirements of treating patients with respect and equal justice. They can also result in violations of human rights laws that prohibit discrimination against women.

1. Stereotypes and stereotyping

A stereotype may be understood as a generalized view or preconception of attributes or characteristics possessed by, or the roles that are or should be performed by, members of a particular group, such as women. Irrespective of individuals' personalities, capacities, or qualities, those perceived as members of the groups are regarded as possessing characteristics that are typical of the group [1] (p.9). Women are frequently disadvantaged and discriminated against by the application, enforcement, and perpetuation of stereotypes concerning what they are able, expected, and/or bound to do. Stereotypes applied to women may be seen as sex-specific or gender-specific, where "sex" and "gender" are regarded as synonymous. The English language requires, however, that for purposes such as explaining bases of selection or discrimination, sex and gender be distinguished, although this is not required in some other languages. For instance, the romance languages such as French, Spanish, and Italian usually introduce masculine-gendered singular nouns by "le," "el," or "il" respectively, and feminine-gendered nouns by "la."

Sex is biologically determined, whereas gender is socially or culturally constructed, as for romance language nouns. In the context of health care, for instance, distinctions used to be drawn between "doctors" and "women doctors," and sometimes remain between "nurses" and "male nurses," because doctoring was preconceived as a masculine occupation, whereas nursing is a function associated with women. In conservative societies where a preoccupation with sex is seen negatively, the word "gender" may be a genteel way of referring to a person's sex. The two words may accordingly be confused and misapplied, such as in "sex-change" operations, which do not change patients' biology, but their gender classification in society.

The stereotyping that disadvantages and constitutes discrimination against women concerns social attitudes, preconceptions, laws, policies, and practices that confine women to feminine-gendered roles, particularly as mothers and caregivers, and exclude women from masculine-gendered roles, such as are discharged by social, political, religious and comparable actors, thinkers, and leaders. The stereotypical preconceptions of weakness, subservience, emotionalism-derived inability to reach or sustain decisions, vulnerability, and dependency associated with women—the "weaker sex"—once precluded women from university education, medicine, law, politics, the sciences and, for instance, religious ministry, which preclusion persists in some religious denominations. Such preconceptions may still affect women as potential recipients of reproductive and sexual healthcare services.

Some stereotyping may be benignly descriptive, allowing a level of superficial understanding in the absence of specific knowledge. Opinions based on generalized stereotypes are convenient, and often inevitable since, as the celebrated commentator Walter Lippmann once explained:

> The real environment is altogether too big, too complex, and too fleeting for direct acquaintance. We are not equipped to deal with so much subtlety, so much variety, so many permutations and

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> combinations. And although we have to act in that environment, we have to reconstruct it on a simpler model before we can manage with it. [2] (p.16)

Stereotypes as simple, or simplistic, models of understanding can be oppressive. When stereotypes are prescriptive, they can be unethical and unlawful; that is, when they are applied to prescribe what individuals must do, or must not be permitted to do. Laws, policies, and practices, for instance, that condition or confine women to mothering or domestic roles, or that prevent women's exercise of reproductive self-determination, have unfortunately been persistent in reproductive and sexual health care.

2. Stereotyping in reproductive health

An historical accumulation of laws, policies, and practices relevant to reproductive and sexual health services continues to entrench adverse stereotypes of women. Common instances are requirements that infantilize women by providing that their requests for health care be approved by their husbands, fathers, or other male heads of their households. Some countries' laws, enacted by legislatures or interpreted by judges, express or imply stereotypical concepts regarding women, such as by emphasizing their expected domestic role as caregivers. In the Republic of Ireland, for instance, the highest law of the land, the 1937 Constitution, provides that "the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved" (Article 41.2.1). In return, "The State shall… endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home" (Article 41.2.2). Accordingly, a childless woman requesting a contraceptive prescription or sterilization in order to pursue her career is stigmatized as denying support to the state and frustrating the common good. Similarly, mothers of young children requesting the same in order to enter or return to paid employment may face accusations of child neglect.

Instances of judges applying negative or prohibitive stereotypes of women are both historical and recent. In 1872, Justice Bradley of the US Supreme Court upheld a woman's exclusion from membership in the legal profession on the grounds that "[t]he constitution of the family organization which is founded in the divine ordinance… indicates the domestic sphere as that which properly belongs to the domain and functions of womanhood" and that "[t]he paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother" [3].

This restrictive stereotype of women as properly confined to childbearing and domestic functions was echoed in 2007 in Gonzales v. Carhart [4]. In that case, the majority of the US Supreme Court stereotyped women as vulnerable, so requiring the protection of (predominantly male) legislators, and incapable of reaching responsible reproductive decisions in their own life plans. The majority upheld legislation prohibiting women's access to a particular abortion procedure their physicians might consider, in their clinical judgment, to be in the women's best health interests.

Legislation prohibiting women's choice of abortion services, invariably enacted by male-directed legislatures, often with support of religious hierarchies that include few if any women, reflects stereotypes hostile to women's claims to health and to women's capacity for moral agency. Countries are progressively liberalizing abortion laws [5], however, accepting that there are circumstances in which women's health interests should supersede state interests in the continuation of pregnancies. Because arguments in favor of fetal interests are proving decreasingly persuasive, abortion opponents are raising new arguments based on claims that women are better protected from the "harms" of abortion by denying them access to that procedure, but cannot recognize such "harms" by themselves [6].

The stereotyped assertion that legislators and judges can better protect women's interests than can women themselves found favor in Gonzales v. Carhart with the US Supreme Court's five-man majority. They upheld the abortion procedure prohibition in question, and the criminalization of physicians who disregard it in order to serve their patients' health interests. Justice Kennedy observed for the majority that:

> Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow. [4] (p.159)

This observation feeds into the stereotype that women are irrational and incompetent decision-makers, who are incapable of reaching difficult and painful moral decisions that they may regret. The risk of regret is inherent in reaching many moral decisions in individuals' lives, however, but this does not justify placing such decisions in the hands of legislators or courts. The decision to continue a pregnancy, for instance, such as of a severely abnormal fetus, can equally be difficult, painful, and a source of regret, but it is generally not considered justified to remove that decision from pregnant women.

The willingness of the Supreme Court's majority to find that, because women may regret their choices, the intervention of legislators is justified for their protection was condemned by Justice Ginsburg, the only woman then on the Court. Justice Ginsburg accepted that physicians' clinical judgment might favor the method of abortion that the legislation in question prohibited, but found that:

> the Court [majority] deprives women of the right to make an autonomous choice, even at the expense of their safety. This way of thinking reflects ancient notions about women's place in the family and under the Constitution - ideas that have long since been discredited. [4] (p.185)

Judicial decisions upholding women's access to reproductive health services are not necessarily more respectful of women's autonomy, but may similarly reflect stereotypes of women requiring the protective judgment of others, such as legislatures, physicians, and judges. For instance, in the 2006 English High Court Axon case [7], the judge upheld the power of intellectually mature adolescents to make reproductive health decisions, including on abortion, without their parents' consent, and also to enjoy confidentiality comparable to that available to adults [8]. Nevertheless, the judge felt bound to apply the legislated stereotype of women being incapable of exercising socially acceptable judgment on abortion by themselves, but being required to satisfy health and social conditions for the procedure, as determined by physicians. Thus, the choices of young women of adult capacity are still subject to the restrictive stereotypes of women applied by legislators, physicians, and judges [9].

In contrast, Justices of the Constitutional Court of Colombia liberalized the prohibitive national abortion law, expressly rejecting the stereotype that women's only natural role and destiny is motherhood, on which that law had been based. Justices Araújo Rentería and Vargas Hernández, writing for the majority, explained that:

> When the legislature enacts criminal laws, it cannot ignore that a woman is a human being entitled to dignity and that she must be treated as such, as opposed to being treated as a reproductive instrument for the human race. The legislature must not impose the role of procreator on a woman against her will. [10]

The Justices thereby laid the foundation to dismantle the stereotype that women should be perceived only as reproductive instruments,

and affirmed women's right to equal dignity with men in their reproductive choices.

Restrictive or demeaning stereotyping in legislation and judicial decisions may also be found in the stereotypes applied by physicians, nurses, and related health facility staff members. Judgmental language and attitudes applied, for instance, to unmarried women requesting contraceptive prescriptions, pregnancy testing, or abortion, or to patients seeking treatment for sexually transmitted infections, reflect stereotypical ideas uninformed by patients' particular circumstances, such as victimization by sexual predators in their neighborhoods, schools, or homes. There is a shameful history of physicians, nurses, and other healthcare providers applying punitive approaches to women seeking abortion procedures, and of them giving vent to moral or religious values of which they find patients in breach. Such conduct is unprofessional, unethical and, in that it is discriminatory, may be unlawful.

3. Unlawful stereotyping

Many national laws and international human rights treaties that countries are committed to apply in their domestic laws prohibit discrimination on grounds of sex or gender. Disadvantage that individuals suffer due to treatment different from that afforded others from whom they are not materially different constitutes discrimination. Women are materially different from men due to physique and reproductive functions, but not in their capacity for moral reflection or understanding of information, or, for instance, their right to self-determination. Accordingly, when men can receive health services without government or state intervention, but women have to satisfy stereotypical legislated, customary, or other criteria inapplicable to men, women suffer discrimination, and this is liable to be unlawful.

Many countries' constitutions, which express the fundamental principles that inspire, guide, and justify the exercise of state power, profess the elimination of discrimination on grounds, among others, of sex and gender. Some national and subnational laws include human rights enactments that outlaw discrimination, by public authorities and by private actors. Such provisions fit within the wider framework of international human rights treaties, most relevant of which to women's reproductive health is the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) [11].

Article 5(a) of CEDAW requires states to take all appropriate measures:

> To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.

This Article fits within the framework of Article 2(f), by which parties undertake to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women."

Health concerns are addressed in Article 12(1), which provides that parties to the Convention:

> Shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

This provision leads to Article 16, on marriage and family relations, under subsection 1(e) of which measures are required to ensure to men and women:

> The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Although framed within provisions on marriage and family relations, this subsection justifies family planning and sexual health education to unmarried individuals, including adolescents. Indeed, Article 10(h), on equal education of women and men, requires states to take all appropriate measures to achieve equality in "[a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Access to reproductive and sexual health services falls under Article 12(1) above, which requires that women, without discrimination on grounds of age or marital status, shall have the same access that males have, for instance, to condoms.

Article 16(1)(e) on determining the number and spacing of children entitles normally fertile women to control their reproduction. However, women whose reproduction requires medical assistance may be subject to legislation. In the practice of in vitro fertilization (IVF), for instance, male contributors' rights may include enacted powers of veto, for instance over use of stored sperm and embryos after their relationships have ended by divorce or separation [12]. These laws may be challenged on grounds of violation of human rights, but ex-husbands' right to prohibit use by their ex-wives of embryos to which they have contributed has been upheld by several national courts, and by the European Court of Human Rights [13]. It is not clear that courts would be more sympathetic to women who could show that they were disadvantaged by male, or institutional, adverse stereotyping. However, in France in 1984, when the Centre d'Etude et de Conservation du Sperme Humain (CECOS) refused to surrender stored sperm to the donor's widow, Corinne Parpalaix, because of its explicit policy of not permitting postmortem insemination, a court in Paris ordered surrender to her [14]. The CECOS policy was not formulated until after the donor had died, and may have reflected stereotypical thinking hostile to single women bearing children.

4. Ethics and moral agency

The ethical objection to the negative stereotyping of women as irrational and incompetent decision-makers is that it denies women's moral agency. That is, the stereotype regards women as incapable of profound reflection on significant matters, but considers such reflection, decision-making, and bearing of responsibility for consequences a male-gendered function. Women are seen to require protection against their liability to make bad or controversial decisions. The US Supreme Court majority, for instance, approved legislators displacing women as decision-makers regarding termination of their own pregnancies because "[w]hether to have an abortion requires a difficult and painful moral decision…some women come to regret their choice" [4] (p.159). Men, as legislators, judges, and leaders of religious denominations, receive deference on such matters, whereas women are infantilized as requiring protection against the burden and social responsibility of being moral agents.

A central principle of modern bioethics is expressed as respect for persons, which allows intellectually capable individuals to make decisions regarding their own bodies and lives, and protecting the interests of those who are incapable. The negative stereotype unethically presumes all women to be intellectually incapable.

A further ethical principle, to which the law is primarily addressed, is justice. This requires that cases that are materially alike be treated alike, and that materially different cases be treated with respect to the difference. Women and men are sexually different, but this is not material to their human capacity to act as moral agents, and to be accordingly responsible for the effects of their decisions. Women and men are alike in their ability, as reflective, conscientious actors in their families and societies, to differentiate between, for instance, reproductive choices and medical care that serve their legitimate goals, and those that are contrary to their interests.

It is critical that clinicians not approach their patients through stereotypes. As Walter Lippmann explained, initial generalizations are

understandably applied to cope with a complex environment that is "too fleeting for direct acquaintance" [2]. Clinicians treating individual patients, however, require direct acquaintance. They must know enough about their patients' circumstances and personalities to satisfy the ethical and legal requirements of determining the treatments they propose. If clinicians lack adequate knowledge, they should make relevant inquiries, which are often most conveniently made by asking the patients themselves and ensuring proper understanding of their responses. This accomplishes the ethical purpose of showing patients respect.

In prescribing drugs, for instance, clinicians must determine suitability and perhaps dosage levels by reference to bioavailability, considering the effect of proposed drugs influenced by patients' age, size, body fat distribution, hormones, and body chemistry. This cannot be undertaken by an impersonal stereotype of what characteristics an individual patient may be presumed to possess by membership of a category of patients. Similarly, in considering treatment options, clinicians should be informed about their individual patients' relevant circumstances, purposes, and priorities. The Supreme Court of Canada ruled a Criminal Code prohibition of abortion an unconstitutional violation of women's human rights to security of the person because it denied a woman the procedure "unless she meets certain criteria unrelated to her own priorities and aspirations" [15]. Patients' priorities and aspirations are specific to each patient, and cannot be prescribed by an impersonal stereotype characterizing the sort of person the patient is perceived to be.

5. Eliminating stereotypes

The purpose of identifying discriminatory stereotypes is that they be dismantled and eliminated [1] (ch. 3). Some stereotypes fade with time as their underlying fallacies and misrepresentations become widely apparent. A stereotype of women's sexual servitude was that by once consenting to marriage, a woman agrees to be sexually available to her husband at any time of his choosing, even by force, although some legal systems have been slower than others in recognizing and condemning sexual and other violence between spouses [16]. Another stereotype in some countries and cultures is the expectation of women's chastity, especially in unmarried adolescent girls. This has faded for instance in the US, where the estimated prevalence of sexually transmitted infections among adolescent girls ranges from 14% at age 14–15 years to 34% at age 18–19 years [17]. Girls in the latter age group are very likely to be unmarried, since ages at first marriage in the US are rising.

History shows, however, that some stereotypes are particularly tenacious, and survive widespread evidence of their inaccuracy, or of their irrelevance to particular circumstances and cultural developments. The stereotype, for instance, that young or adolescent women embody their families' honor has resulted in their victimization by so-called "honor killing" on suspicion of sexual impropriety, even in countries into which their families immigrated a generation or more ago where this stereotype had never existed or had long been discarded.

The ethical responsibility of medical associations, healthcare facilities, and individual health service providers is to be aware of the harmful and discriminatory stereotypes, particularly of women, under which they and others in reproductive and sexual health service delivery have practiced and continue to practice and to challenge such stereotypes, for instance by reference to their experiences of the realities of actual patients' lives. Stereotypes are weakened by individuals' exposure to a succession of instances that show them to be false. They may be perpetuated, however, when those in public authority, whether political, judicial, or religious, are motivated by doctrinal convictions or by self-interest to preclude women from comparable and competing authority, or are remote from the realities of women's sexual and reproductive lives, such as senior office-holders unaccustomed to meeting with women on terms of equality.

The challenge in reproductive and sexual health care is to recognize that patients' human rights to respect, dignity, and self-determination impose professional duties on healthcare providers. The initial presumption, or neutral stereotype, should be that women are competent decision-makers with respect to their bodies and lives, and capable of accepting moral responsibility for their appropriately informed choices. Their choices should not have to be ratified by men, such as husbands or fathers, or disclosed to others without the women's prior approval.

Evidence of lack of patients' comprehension or of immaturity should be carefully evaluated. For instance, adolescents who are too young for certain purposes, such as marriage without parental consent, may have the intellectual, legal, and moral authority to determine the health care they require or will accept, reflecting their evolving capacity for responsible choice, and the values to which they adhere [18]. Some courts have a long history, for instance, of allowing adolescents of early teenage years who are Jehovah's Witnesses to decline medically indicated blood transfusion or products. Further, adolescents found incapable of such self-determination may nevertheless be entitled to confidentiality concerning the care they have requested [8].

Treating patients with respect is particularly challenging when they make decisions that providers responsible for their care consider ill-judged, harmful to their health, or harmful to others, their families or communities. The right to poor choice may not attract strong defense, but is inherent in the right to self-determination. Providers unable to persuade patients against their poor decisions may ultimately withdraw from the professional relationship, in accordance with ethical and legal requirements, particularly those against abandonment.

As a professional duty, healthcare providers should be active to eliminate negative, harmful, or discriminatory stereotypes, because such stereotypes are inimical to health and health care. The World Health Organization recognizes that "health" is a state of "physical, mental and social well-being, and not merely the absence of disease or infirmity" [19]. Patients whose healthcare providers discount their individuality but treat them through impersonal, demeaning, simplistic stereotypes cannot be considered to have received contributions to their mental or social well-being, or therefore to their health.

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