Canadian Bioethics Society

NEWSLETTER

Volume 5, Number 1

February 2000

PRESIDENT'S LETTER

Marianne Lamb 1999-2000

It is a pleasure and an honour to begin my term as President of the Canadian Bioethics Society for 1999-2000. I am fortunate to work with a knowledgeable and experienced Executive Committee: Thérèse Leroux (Past President), Paula Chidwick (Communications Officer), Chris MacDonald (Atlantic), Kathleen Glass (Eastern), Jeff Nisker (Central), Kathy Oberle (Western). You will see information in this Newsletter regarding the Nominating Committee's search for a President Elect and we hope to have a full Executive Committee membership soon.

The 11th Annual Conference in Edmonton was an unqualified success and great thanks are due to Vangie Bergum, her team and volunteers on the local planning committee who did a magnificent job. The Pre- and Post-conference workshops as well as the Annual Conference were well attended and the participation of Board Members of the International Association of Bioethics contributed to the program and discussions.

For more than a decade, the Society has played an important role in promoting and supporting scholarly debate and exchange, ethics education and networking that brings individuals together, from a variety of disciplines, who are interested in bioethics. The Society continues to evolve and change over time, as evidenced by a number of decisions taken at the Annual Meeting in October. Despite some discussion about membership categories and the objectives of CBS, members approved a new Constitution for CBS. It is understood that the Constitution will undergo continuing review and amendment, and Thérèse Leroux encouraged those with comments to send them in. So, look at the last copy of the CBS Newsletter (August, 1999) to see the Constitution that was adopted and let us know if you have proposals for changes.

This year, as a result of a well-attended Network Luncheon on working conditions for bioethicists, the membership agreed that CBS should convene a panel to examine the topic in greater depth and to report back at next year's annual meeting. The Executive Committee

... continued on pg. 2

In this issue...

Candidate for President-Elect 3

12th Annual Conference 4

Final Report. 5

Student Representative Report. . . 6

Call for Abstracts 7

Working Conditions for Bioethicists. 8-9

Gender, Risk and Reproductive Decision-Making 10

Nomination Ballot 15

Canadian Bioethics Society

NEWSLETTER

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Newsletter Editor

Paula Chidwick

This newsletter is published in both French and English and is distributed to CBS members in their preferred language. Members can obtain an additional copy in the alternate language upon request.

Newsletter submissions in the form of articles, letters, book reviews, notices and events are welcomed.

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***President's Letter** – continued from pg. 1 …*

has asked George Webster to chair the group and we hope that there will be some preliminary outcomes of this group's work available in time for the next Newsletter, in preparation for discussion at the next Annual Meeting.

The next Annual Meeting will be held in Québec City and Edith Deleury and her team have been working to ensure that we have another excellent conference. The theme for the conference is "Medicine, technology and humanism: an alliance against nature?" and the date for the conference is October 19 to 22, 2000. Keep your eye on CBS Newsletters and the CBS Website for up-to-date information.

During the coming year, CBS will make extra efforts to determine the needs and wants of members with regard to the activities of the Society and to bolster membership. We will be surveying members on this topic, but in the meantime, we welcome your thoughts and comments.

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Letter from the Editor

Paula Chidwick

Paula Chidwick

Welcome to the first issue of the 2000 CBS Newsletter. This newsletter was created to promote more effective communication between society members. It serves to inform members about society news, the Annual Conference and current ethical issues facing Canadians. As such this newsletter strives to remain an important source of information for members. I invite and encourage members and especially student studying in this field to use this forum for discussion. In the next two issues there will be society news with regular reports from the President, Conference Planning Committee Chair, Student Member-at-Large and Nominating Committee. There will also be a focus this year on the Working Conditions for Bioethicists with a report in the second issue from the chair of the new committee – George Webster. Each issue includes announcements, advertisements and postings. You can submit material to the editor at ***pchidwic@uoguelph.ca*** in ***Richtext Format***.

pchidwic@uoguelph.ca

CANDIDATE FOR PRESIDENT-ELECT (1999-2000)

The Nominating Committee is pleased to forward the name of Dr. Christine Harrison for the position of President-Elect (1999-2000) of the Canadian Bioethics Society.

Christine Harrison has worked as a bioethicist at the Hospital for Sick Children since 1993, and is currently director of the Bioethics Department, assistant professor in the Department of Paediatrics, and a member of the University of Toronto Joint Centre for Bioethics. Her current research interests include ethical aspects of health care decision-making for, and by, children.

Christine received her PhD in Philosophy from McMaster University. She did a post-doctoral fellowship with McMaster's Geriatric Research Group, looking at the concept of personhood in the context of Alzheimer's disease.

Christine has been a member of the CBS since its formation, serving twice on the Advisory Committee, and chairing the CBS conference in 1998. She lives in Guelph with Ron, Bear, George and Gracie (husband, dog, and cats, respectively).

In accordance with the rules of procedure, we invite members to submit additional nominations for this position by March 15, 2000. If an election is required, a mail-in ballot will be distributed to members in a subsequent mailing. A Ballot form is located on page 15.

"Medicine, technology and humanism: an alliance against nature?"

12th ANNUAL CANADIAN BIOETHICS SOCIETY MEETING

will be in Quebec City, Quebec *at the* Quebec Hilton *on*

October 19-22, 2000

For more information contact:
Edith Deleury
Phone: (418) 656-3480
E-mail: Edith.Deleury@fd.ulaval.ca

* * *

Please mark on your calendar

* * *

12TH ANNUAL CANADIAN BIOETHICS SOCIETY CONFERENCE

MEDICINE, TECHNOLOGY AND HUMANISM: AN ALLIANCE AGAINST NATURE?

Quebec Hilton, October 19-22, 2000, Quebec City

Scientific and technological advances contribute more and more, and at an increasingly rapid rate, to the practice of medecine: medical imaging, teleconferencing, and medically assisted procreation are just a few examples. The development of research in such areas as cell-line therapy, xenotransplantation, and embryonic stem cells research allows us to foresee possible clinical applications for these techniques in the short and intermediate term.

Will these advances inevitably lead to the dehumanization of medicine? Surely humankind possesses the resources necessary to ensure that these scientific and technological developments will, in fact, lead to significant progress for humanity.

These are the questions the CBS invites you to explore during its 12th annual conference. Three main issues have been proposed to orient future discussion.

The first issue deals with two types of change resulting from advances in science and technology. First, the doctor-patient relationship has undergone significant transformation, particularly in an environment where specialties are becoming more and more technical: medical imaging, teleconferencing, etc. In a clinical context, many questions arise regarding the increasingly mediated relationship between doctors and their patients. Second, there has also been a change in the cultural perception of the human body and nature. In this regard, we need only mention the numerous treatments made possible by developments such as NTR, cloning, the therapeutic use of embryonic stem cells, xenotransplantation and germ cell-line therapy.

The second issue concerns the relationship between technological developments and increasing health costs. An analysis of this relationship must necessarily begin with a reflection on the goals of medecine. Is the goal of medicine to render human beings immortal? Or is the goal "simply" to supply a service in response to a demand? It is no doubt easier, in this area, to identify the roads we want to avoid than to define the paths that are feasible and desirable from an ethical point of view! Furthermore, an analysis of the increase in costs is necessary to understand the factors which contribute to this increase. Finally, we cannot avoid the painful issue of the constraints surrounding public healthcare. What services will public healthcare be able to offer in the future? What services must it offer? We could even ask the following question: "Does public healthcare have a future?"

The third issue involves the relevance of normative discourse. Can these factors play a guiding role in a context of economic globalization? It seems today that the only universally accepted laws are "the natural laws of the economy." Must we therefore consider normative discourses to be ineffective? This perspective puts the issues into a political context and obliges us to question ourselves about the democratic control of scientific developments which have a profound effect on cultures and ways of life. An analysis of the "Canadian case scenario" regarding reproductive technologies could prove to be highly instructive in this regard.

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Vangie Bergum

Final Report

By Vangie Bergum

This year, the Annual Meeting of the Canadian Bioethics Society was held at the Westin Hotel in Edmonton, October 28-30, 1999. The conference with the theme of *Expanding the Boundaries of Ethics* was attended by 314 registrants from all parts of Canada, the United States, and from around the world. A pre-conference *Health Ethics: The Global Context* was held on October 28th with 170 attendees, and two post-conferences, *Ethics, Health Care, and Resource Allocation at the End of Life* (100 attendees) and *The Ethics of Health Research Using Qualitative Methods* (57 attendees), held on October 31st, were important additions to the conference.

A special feature of the 1999 Annual Conference occurred with the attendance of eighteen members of the International Association of Bioethics Board who held their annual meeting at the time of our conference. The pre-conference and the opening evening featured our internationals guests: Alastair Campbell (UK), Godfrey Tangwa (Cameron), Susan Sherwin (Canada) as well as Marie Fortier (Health Canada). The Thursday public meeting focussing on the question *Can Bioethics be Local when Biotechnology is Global?* received considerable media attention.

The conference featured keynote addresses by Martin McNeally, Madeleine Dion Stout, Jon Amundson, our current Past-President Thérèse Leroux, and John Dossetor who challenged us to think of healthcare ethics in diverse ways. A new feature of this year's conference were three invited Symposia exploring *HIV/AIDS Vaccine Research, End of Life,* and *Ethics and Cultural Diversity.* Contributing to the success of the conference was the quality of the concurrent research presentations (69 paper, 15 poster), the networking lunches, the lively annual general meeting and the many opportunities for dialogue amongst participants. The reception following the opening meeting on Thursday evening and the social event on Friday evening (a special opportunity for viewing the poster presentations) provided opportunity for eat, drink and conversation.

The planning committee, lead by members of the Provincial Health Ethics Network, St. Joseph's College Ethics Centre, and John Dossetor Health Ethics Centre, University of Alberta, included individuals representing a broad base of health ethics interest across Alberta. The committee members were pleased with the wonderful response of colleagues from across Canada who came to the conference and made it the success that it was. The conference benefited from funding support in terms of Lectureships, Grants, and Donations – and for this support members of the CBS and the planning group are extremely appreciative.

If any of you have further comments or suggestions about the conference please send e-mail.
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Student Representative Report

By Chris MacDonald

Chris MacDonald

As those of you who were at the Annual Meeting already know, although I'm officially the Member-at-Large for the Atlantic Region (on the CBS Executive), I've also agreed to act informally as Student Representative. *(See the August '99 issue of this Newsletter for an explanation of the Constitutional changes behind this.)*

I'll begin this Report by congratulating the winners of the 1999 Student Abstract Competition:

Andrea Frolic, Rice University: Fusing horizons: Resolving intercultural ethical conflicts in the clinical setting
Maya Goldenberg, McGill University: Sexuality in the nursing home
Sarah McIntosh and **Sara Hamilton**, University of British Columbia: Is informed consent required for prenatal ultrasound, or can it be ordered as a routine examination?
Dawn Dudley Oosterhoff, University of Toronto: Medical futility: A new perspective on a red herring
Jason Scott Robert, University of Chicago/McMaster: Bioethics beyond Georgetown
Christy Simpson, Dalhousie University: Hope, health, and the doctor-patient relationship
Brigitte Nepveu, University of Montreal: Etude comparative de diverse approches normatives propres au clonage therapeutique et reproductif

As anticipated, students were highly visible at our recent CBS Annual Meeting in Edmonton. At our annual Student Luncheon, students met to discuss common goals and interests, and came to a number of significant decisions. Several ideas were generated for raising further the visibility of students at next year's Annual Meeting, and these have been passed along to the Quebec City Organizing Committee. We also discussed options for how to spend the pot of money generated by student-let activities at last year's Annual Meeting in Toronto. This discussion will be continued on the new Student E-mail Network (about which see more below.) Students also came up with a number of novel suggestions for increasing CBS membership, and these ideas have been passed along to the CBS Executive.

One of the most significant moves made at the Student Lunch was the decision to renew the idea of having a mailing list for student members of the CBS. It was felt by those students present that such a list would be useful for a range of things, including exchanging information about upcoming conferences, tips on job hunting, exchanging drafts of papers, and discussing current issues in bioethics. To that end, an e-mail list was set up. In order to subscribe, you must be a current student-member of the CBS.

Compose a message to
listproc@noc.dal.ca
with the following in the body of the message
sub cbs-students MyFirstName MyLastName where the names are your own real names.
(The "subject" line of the e-mail doesn't matter.)
If anyone has any questions about this list e-mail list, feel free to contact me.

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The Canadian Bioethics Society
has its own page on the World Wide Web!
Check out the site at
http://www.bioethics.ca

CALL FOR ABSTRACTS

12TH ANNUAL CANADIAN BIOETHICS SOCIETY CONFERENCE

Medicine, Technology and Humanism: An Alliance Against Nature?

QUÉBEC HILTON, OCTOBER 19-22, 2000, QUÉBEC CITY

The possible formats for presentations are papers, workshop, and posters.

Papers: Authors wishing to be considered for a 20-minute oral presentation (not including discussion time) must submit a two-page, double-spaced outline of the proposed paper as well as a 250 word abstract on the official form. Authors should indicate whether they wish their paper to be considered for a poster presentation.

Workshops: Groups of authors wishing to present their work in the format of a one-and-a-half hour workshop must submit a three-page double-spaced outline of the proposed workshop and a single 250 word abstract on the official form.

Posters: Authors wishing to be considered for a poster presentation must submit a 250 word abstract on the official form. Materials for a poster presentation must fit into a 1,20cm x 1,20cm space.

Official Abstract Form: Abstracts must be submitted camera-ready on the official abstract form because all abstracts selected for presentation at the conference will be reproduced in the conference syllabus. Official forms are available from **Bernard Keating**, Faculty of theology and religion, Félix-Antoine Savard Pavillion, Laval University, Sainte Foy, Québec, G1K 7P4. You can also download the Abstract Form from the internet (www.ftsr.ulaval.ca/~cbs2000).

Student Composition: Students may elect to submit abstracts to both the general competition and the student competition (students need not identify themselves as students for the general competition). However, the format is not the same for the two competitions. For information on the student competition, contact **Bernard Keating**, Faculty of theology and religion, Félix-Antoine Savard Pavillion, Laval University, Sainte Foy, Québec, G1K 7P4.

ABSTRACTS MUST BE RECEIVED BY **JUNE 15**, 2000.

Please make submissions and direct inquiries to:

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WORKING CONDITIO

Michael Coughlin

Employment/Disemployment Conditions for Clinical Ethicists

REPORT ON A COLLOQUIUM

By Michael Coughlin

During the past CBS Annual Meeting, a lunch-time colloquium was held around employment issues affecting clinical ethicists. The discussion was led by Abbyann Lynch and presentations were given by Abbyann, George Webster, Pat Murphy, Michael Coughlin, Christine Harrison and Mary Rowell. Because of very concrete situations that we all had experienced or had close knowledge of, we felt that this aspect of clinical ethics needed to be discussed openly. Much attention has been given to the functions of the clinical ethicist (education, consultation, policy review/formulation, etc.), to competencies, to character traits, and to accountability. However, little attention has been given to appropriate working conditions, to employment and disemployment (termination) practices. The issue was raised a few years ago by Benjy Freedman in the *Health Care Ethics Consultant* (1994). It also has been addressed in the report of the American Society for Bioethics and Humanities: *Core Competencies for Health Care Ethics Consultation* (1998). This report specifically calls attention to the threat to integrity that can arise from the potential conflict of interests when ethics advice may be against the institution's perceived interests (*ibid.* pp.22, 29-30). Our goal in the workshop was to raise the interest of CBS members in what is "ethically acceptable" in these practices. We believe it important that the CBS develop ethically acceptable standards for such employment/disemployment practices.

The presenters offered examples of cases that raised serious questions about the ethics of threatened or actual terminations of ethicists, as well as some model cases of support by an employer in a difficult situation. Reflection on these cases and on the experience of ethicists gleaned from a pilot questionnaire will be the subject of a subsequent article. However, to clarify the kind of issues that are at stake, a very public example from the States will give some idea of the issues. Several years ago, the University Hospital associated with the Medical University of South Carolina entered into a collaborative program with police and social services in which pregnant women coming to the center would be tested without their knowledge for illegal drug use. Those who tested positive received forced treatment or seclusion until birth in order to protect the children. Once this (inevitably) got to the media and the courts, the Director of the Ethics Program at the Medical University (Mary Faith Marshall) was called as an expert witness. She testified that such a practice ran counter to the University Hospital's own policy on informed consent. Subsequently, a promotion recommended by her department was vetoed by the President of the University because she had not been "loyal". It is this demand for "loyalty", for being a "team player" that tends to create conflicts especially for the ethicist. It is often experienced as a demand for moral compromise on the part of the ethicist.

Ethicists are especially vulnerable because they have neither union nor professional organization to act on their behalf (except potentially when they have a University appointment). Despite the business standards set even by industry (Termination Conference, 1999), hospitals still tend to dismiss people in a secretive way. For non-unionized employees, including ethicists, the procedures are, for the most part at the discretion of the Executive and vary from institution to institution. These practical issues are dealt with very little in courses or textbooks for prospective Human Resource managers. Learning comes on the job with help from consultants, usually "outplacement"consulting firms, among whom there is little consistency or evidence-based practice. The person to be terminated is called into a meeting in the morning, given the news, and escorted off the premises by a security guard. Rarely are they given advance notice. Such treatment does not honour the dignity of the person and tends to poison the quality of work life for those that are left behind (Morin & Yorks, 1982). The provision, now common, of outplacement counseling and severance packages helps cushion the blow financially, but does not make up for the blow to the employee's self esteem (Eby & Buch, 1998). At the Annual Business Meeting the CBS set for itself the task of developing a set of standards or expectations that could be used to judge the appropriateness of employment/disemployment practices in regard to clinical ethicists.

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American Society for Bioethics and Humanities (1998).Core Competencies for Health Care Ethics Consultation. See especially Section 5: Special Obligations of Ethics Consultants and Institutions, pp 29-30.

Lillian T. Eby and Kimberly Buch (1998). The impact of adopting an ethical approach to employee dismissal during corporate restructuring. Journal of Business Ethics 17(12): 1253-1264.

Benjamin Freeman (1994). From avocation to vocation: Working conditions for clinical health care ethics consultants. In *The Health Care Ethics Consultant* (F. Baylis, editor), Humana Press, Totowa, NJ: pp 109-131.

Terminations in an Era of Business Change Conference (1999), Federated Press, Toronto.

William J. Morin and Lyle Yorks (1982). *Outplacement Techniques.* Amacom, New York.

NS FOR BIOETHICISTS

Christine Harrison

Questions to ask about a job as a Bioethicist?

By Christine Harrison

When a bioethicist has applied for a position it important that she have a good understanding of what the job entails and what the expectations are. If this understanding does not exist, or is not shared with the employer, there may be disagreement, conflict – or worse – in the employer/employee relationship.

I suggest that the bioethicist should be able to answer the following questions, although explicitly exploring and seeking answers to them might best occur during negotiations **after** the position has been offered, rather than during the interview. A shared understanding of these issues will also facilitate a meaningful employment contract and job description.

1. Why does the organization wish to engage a bioethicist?

There may already be a bioethics program within the organization. If so, the expectation may be that the new bioethicist will continue on in the same vein, or perhaps the organization wants a significant change.

There may have been an event, or specific factor, that prompted the decision to hire a bioethicist. For example:

- a recommendation by hospital accreditation body
- a new educational initiative, e.g. when the Royal College of Physicians & Surgeons of Canada introduced bioethics into their required curriculum
- a significant "incident" – perhaps a law suit, or a patient care disaster or "near miss"

2. Are there groups or individuals within the organization that might have different needs and expectations regarding the role of the bioethicist?

It is important to know if there is a clinical ethics committee and research ethics board in the organization, and what the relationship of the bioethicist will be with these groups.

In order to understand the type of work you will do, you need to know that members of the organization are of one mind (or at least do not have wildly diverse ideas) about what is needed from the bioethicist. Senior administrators may want a national or even international bioethics "star", whereas frontline workers may want someone to help them with specific patient care issues.

3. Assuming that priorities regarding the bioethicist's time and energy will have to be established, who is to set them, and how, and will the bioethicist be supported in the face of the disappointment of those who feel underserved?

4. Will the bioethicist have protected time for research?

One hospital administrator was heard to say "why does he need a study leave – why doesn't he do his research the same way we do – between midnight and 3 in the morning?"

This is especially important to reach agreement on, especially if performance will be assessed to some extent on research productivity. There should also be some mutual understanding about what bioethics research *is*, and how the bioethicist's research program will be established. For example, I moved from a geriatric setting to a pediatric one, and I believe there was a perfectly reasonable expectation that the type of research with which I am involved would change accordingly.

5. Who is your boss?

This may seem like a simple question, but it is not always so, and it is a crucially important one. It is perfectly reasonable to require an answer to this question before accepting a position. The person (or position) to whom one reports should understand what a bioethicist does, and be able to advocate for the bioethicist and her program at senior levels. There may be danger in not knowing to whom you are accountable, or to be directly accountable to more than one person.

6. What does it mean to do one's job well, or incompetently, TO ME? What does it mean to do my job well, or incompetently, TO THOSE WHO HAVE POWER OVER ME? What happens when we disagree?

A good bioethicist will constantly strive to do good work, and must therefore reflect on what this means, to herself, to her employer, to her organization, and the community she serves.

Christine Harrison is the Director of the Bioethics Department at the Hospital for Sick Children.
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Elisabeth Boetzkes

Gender, Risk and Reproductive Decision-Making

By Elisabeth Boetzkes

In 1979 Abby Lippman and F. Clarke Fraser conducted a series of studies investigating women's decision-making after genetic counselling[1]. Rather than supporting the received wisdom about decision-making under uncertainty, which predicts that rational individuals will incorporate probabilities into their utilities for foreseeable outcomes, the research of Lippman and Fraser revealed a different pattern of decision-making. Women at risk of conceiving an anomalous fetus employed the strategies of simplification and neutralisation. That is, they simplified the futures by reasoning bivalently (either they will or will not conceive an anomalous child) and explored the 'worst-case scenario' using moral imagination, narrative, and dialogue with other women facing similar choices or experiencing the consequences of similar reproductive decisions. This imaginative and dialogical process allowed the women to 'neutralise' each outcome, by assessing its personal acceptability. The probabilities played no role in their decision-making process.

Commenting on the significance of these research findings, Barry Hoffmaster says,

> The work of Lippman and Fraser shows that a maximise-subjective-expected-utility model misrepresents and distorts the phenomena of post-counselling reproductive decision-making in virtue of the three features it shares with a deductive-system model of morality: it ignores the contexts in which problems arise, it regards decision-making as a static enterprise, and it is predicated on a formal notion of rationality[2].

Iris Marion Young and Catriona Mackenzie have also drawn attention to the distinctiveness of women's reproductive decision-making, and in particular to the role of bodily experience and social context. Both argue that abortion decisions are shaped in part by the phenomenology of pregnant embodiment and the need to test out maternal self-understandings against the models of maternity presented to women within the broader culture. Abortion decisions are necessarily dynamic and individual. As Mackenzie says,

> The fetus is not simply an entity extrinsic to (the pregnant woman) which happens to be developing inside her body and which she desires to remove or to allow to develop. It is a being, both inseparable and yet separate from her, both part of and yet soon to be independent of her, whose existence calls into question her own present and future identity.[3]

Sorting out an appropriate self-understanding will thus play a role in women's decision-making about continuing a pregnancy. The process will address individual and social concerns. Motherhood may be perceived as an avenue of personal achievement, or as a daunting social burden. For, as we know, maternity invites a range of social responses, from censure to approval, depending upon factors such as age, marital and socioeconomic status, and sexual orientation. Pregnant women making the decision whether or not to proceed with a pregnancy must integrate such social, phenomenological and moral data into an acceptable self-understanding to support their decision. Such a decision-process must involve the exercise of moral imagination and the construction of personal narratives, sometimes without, but frequently with, the narratives of others to inform the process.

"Pregnant women making the decision whether or not to proceed with a pregnancy must integrate such social, phenomenological and moral data into an acceptable self-understanding to support their decision. Such a decision-process must involve the exercise of moral imagination and the construction of personal narratives…"

While these examples may reveal the dynamics of reproductive decision-making, what do they say about rationality? Is the resistance to quantificational decision-making and the preference for moral imagination and dialogue rational? This is an important question

for two reasons. First, if we adopt a rigid model of rationality – such as the one that dominates discussions of risk decision-making – deviation from it will be taken as evidence of irrationality, and to the extent that holistic and exploratory approaches are typical of women, the stereotype of women's irrationality will be reinforced.

A further hazard for the status of women as reasoners emerges from the marriage between formal models and the notion of expertise. Although in principle a subjective element in the assignment of values to variables in cost/benefit analysis is acknowledged, the assessment of risk is often taken to be a matter for scientific experts alone. The conventional model is: experts tell you the probabilites, and you evaluate the outcomes based on this assessment. Yet determining probabilities is itself a value-laden activity, as Shrader-Frechette and others have shown[4]. Furthermore, some weightings of outcomes are viewed as aberrant, and discounted as 'merely subjective'. In environmental risk assessment, for instance, risk-taking strategies are commonly (and dangerously) taken as the most rational responses to projected alternatives, and the more cautious responses characteristic of women (and, incidentally, of all categories other than white males) are dismissed as faulty[5]. Yet differences in values due to socialising and circumstances have most likely shaped different value priorities, priorities which cannot be dismissed out of hand as irrational.

The cult of expertise in risky decision-making is particularly problematic in clinical settings. A heritage of paternalistic medicine has created a context in which physicians' judgments are taken as objective (and, of course, much hangs on them) while patients or clients are often discouraged from challenging such judgments or arriving at conclusions of their own. Yet systematic biases may infect medical judgment. Physicians have been shown to model aging in terms of deterioration, decay and death, and to have an exaggerated fear of all three.[6] In research concerning physicians' attitudes towards hormone replacement therapy, systematic discrepancies between physicians' formal assignment of values to outcomes and their own clinical recommendations appear[7]. That is, while physicians will favour HRT in experimental decision-settings, in clinical settings they are more conservative, due, it is hypothesised, to an aversion to recommending a therapy which creates a risk of endometreal cancer, even though in theory the risk is low (when estrogen is accompanied by progestin). The danger of physician bias against HRT is exacerbated by two further factors: first, that physicians are known to differentially discount women's reports on their health, and, in the context of treating menopausal women, to favour psychogenic explanations of women's symptomology; second, physicians score poorly when tested on whether women are more concerned about vasomotor disorders (hot flashes) or the effects of osteoporosis (physicians think the former, women say the latter). The women studied view HRT positively because of the danger and debilitation of brittle bones. But, if women view their physicians as experts, inappropriate or undesired interventions may result: counselling where women might prefer HRT; or HRT, where women (who are less likely than their physicians to pathologise menopause) might prefer to tackle the problem of bone fragility by exercise and diet alone.

In light of the threat to women's status as rational beings and the dangers to women's well-being of reinforcing the cult of expertise, should feminists reject the formal models of rationality tout cort in favour of the holistic, exploratory approach?

I think there are sound reasons to resist the exclusionary or hierarchical tactic, and to adopt an inclusive approach instead. First, we surely do not want to dismiss as irrational all attempts to estimate dangerous futures, where estimation is appropriate (say, in policy formation). Nor should we legislate sameness of psychologies.

Should we, then, argue for a gender divide? Again, there are good reasons not to take this path. First, there is evidence that women are not alone in the resistance to quantificational approaches to decision-making. Narrative methods of information dissemination appear to be more effective in informing the public at large about, for instance, environmental issues than listing the numerical data. Furthermore, women do not **always** resist the conventional approach. There is very little gender-sensitive data on decision-making under uncertainty, but some studies (for example, Kristin Luker's analysis of women seeking serial abortions)[8] in fact do assimilate women's decision-making strategies under the maximising subjective utilities model. It is not necessary, then, to generalise the decision-strategies of the women in the Lippman/Fraser studies across all decision-situations, or, indeed, across all women. Neither is it advisable. For expecting a gender divide runs the risk of essentialising the exploratory psychology to women and the quantificational to men, and this hardly promises to enhance women's status! Rather, feminists should argue for a recognition of difference, and should urge decision-theorists to engage with empirical research on the variety of decision-strategies rather than limiting themselves to the formal models and shaping their experiments with categories designed to reveal or reinforce the received view.

Second, insofar as the traditional approach reveals biases

… continued on page 12

Gender, Risk and Reproductive Decision-Making
– continued from page 11

that are dangerous for women's well-being (such as the physician bias discussed above) the traditional research is important. The critique of the practice of relying on experts has already borne fruit in clinical contexts in the call for heightened self-education and self-determination by patients or clients. Exposing the mistakes of professional reasoning contributes to this trend.

Another important reason to preserve a role for standard risk estimation derives from studies conducted in 1993 by Kolker and Burke[9]. While the findings of Kolker and Burke support the earlier Lippman/Fraser studies, they add a troubling new insight. In exploring the risk perceptions of subjects they found that, after testing, subjects viewed themselves as being at low risk of anomalous pregnancies, notwithstanding the factors of false negatives and undetectable problems. The subjects felt that, by undergoing diagnosis they had explored all avenues to protect the health of their prospective children and having discharged that responsibility, viewed a negative outcome as unlikely.

While this finding corroborates the significance of striving for a morally acceptable course of action (which, of course, is rational), it reveals a dangerous relation between moral self-assurance and real risks of harm. It is not a surprising finding, since there is a well-known connection between reduced risk-perception and control in relation to macro-level environmental decision-making. However, it poses a threat to women's well-being insofar as it induces complacency about truly problematic outcomes. Legitimating risk estimation in these circumstances, without displacing the exploratory approach of decision-makers would clearly be beneficial.

Some practical recommendations fall out of this brief overview. First, in disclosure situations there must be appropriate support for the modes of decision-making likely to prevail. If women making momentous decisions need access to narratives, they should have it. If numbers are meaningless, stories should be told. Likewise, support groups of similarly situated individuals should be organised.

Second, insofar as biases and negative metaphors influence the attitudes and recommendations of physicians, disclosure should be a collaborative process, involving, perhaps, social workers or chaplains as well as physicians.

Clearly, caregivers need to communicate with their patients better. The studies on menopause show that physicians sometimes displace patient preferences with their own. This information should give them pause. More importantly, measures which strengthen the confidence of patients and provide avenues for their self-education are needed.

Finally, strategies for separating the confidence in outcome persons feel by merely exercising control from confidence in outcomes themselves because the decision-process has been rational are needed. Expanding, and rendering more realistic, our conception of the processes of rationality plays an important part in serving that end.

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NOTES

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