Anticonceptie voor gehandicapten?

Birth Control for the Disabled?
Caregivers Should Look at Norms for Legitimate Self-Defense

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Here is a question on bioethics asked by a ZENIT reader and answered by the fellows of the Culture of Life Foundation.

Q: *My friend has a 21-year-old daughter who suffers from a developmental disorder that makes her behave significantly younger than she is. I too have a daughter with a similar disorder (she's 12). Because some people prey on girls who do not understand what is going on or do not have the reasoning skills to stop a situation, my friend put her daughter on "birth control" to protect her. She has, of course, talked to her daughter about what is appropriate touching and what is inappropriate. But she still fears for her daughter's safety. I know from my experience that my daughter often does inappropriate things unknowingly. I understand this mother's worry, but I wonder if there are any moral concerns with doing this?* — D.U., Wichita, Kansas.

E. Christian Brugger offers the following response:

This question bears upon two areas of ethical analysis, the first dealing with norms for legitimate self-defense, and the second with norms guiding the exercise of proxy decision making (i.e., making decisions on behalf of other people).

At first glance, one might think the question also — even primarily — bears upon norms of sexual ethics: "Are contraceptive acts ever legitimate to choose?" But this would be to confuse the issues. When Catholic teaching, at least in the last hundred years, has formulated its negative norm against contraceptive acts, the norm always has been specified in relation to persons who are freely choosing sexual behavior. In each case, it teaches that when couples are engaging in sexual intercourse, if they choose to render that intercourse sterile, they do wrong. This is the case with Pius XI in Casti Connubii (No. 54), Pius XII in his Address to Italian Midwives (1951), Paul VI in Humanae Vitae (No. 14), and John Paul II in Familiaris Consortio (No. 32).

But in the question above, we are not dealing with a woman who is freely choosing sexual intercourse. We are dealing with the potential victim of a sexual assault — rape. Rape is an act of forcing another person into sexual intimacy against his or her will. A female victim of rape certainly has no obligation to submit to her rapist's assault. And she rightly resists her assailant. The attacker's sperm is an extension of the attacker

himself. Just as it would be legitimate for her to defend herself against him by attacking his person, or to pull herself away from him as he penetrates her vagina so he does not ejaculate inside her, so too she has a right to prevent his sperm from achieving the completion of his act of aggression by fertilizing her ovum. This act on her part is one of self-defense. And the Church has always taught that proportionate measures used to render an aggressor incapable of causing harm are legitimate.

The USCCB's Ethical and Religious Directives for Catholic Health Care Services (5th ed., 2009), directive 36, sets forth the following norm:
A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.

Although this directive specifically addresses women who have already been victimized, I believe it is legitimately extended to potential victims of rape. If a woman anticipates being raped, as may occur in a time of war or social unrest or if she is particularly vulnerable, as in the case of the disabled, she may use preemptive measures to defend herself (her ovum) from a rapist's attack (his sperm), provided those measures are not abortifacient.

When a woman is not adequately equipped to defend herself, it may fall to her caregivers to take reasonable measures on her behalf. One who is authorized to make or execute decisions on behalf of another is called a proxy. (Strictly speaking proxies are authorized by those on whose behalf they act; since a cognitively disabled person may not be in a position to formally authorize another, caregivers, such as parents, who rightly make decisions for dependent children, are not really proxies; but for purposes of this reply, I use the term proxy.)

If parents have reason to believe that their disabled daughter (or son) may be sexually victimized, they have a duty to consider their morally legitimate options for defending their child. My colleague William E. May formulates the general norm as follows: "If the health or life of a fellow human person for whom we have responsibility (as parents do for their children) is in danger and there are means that can be taken to protect and/or enhance that person's health and life and/or ameliorate his or her condition without imposing grave burdens upon that person, then we are morally obligated to authorize use of those means" [1].

Good proxies, therefore, will consider at least two things. First, they will make a realistic assessment of whether a woman is in fact at risk; and second, if she is, they will adopt the least burdensome (to her) means for protecting her. I will briefly comment on each.

Caregivers should be careful not to take measures, especially ones that could impose burdens on another, without serious reasons. Thus, parents should examine the empirical literature on the issue, consult with local law enforcement, and perhaps also with trustworthy behavioral specialists, in order to assess realistically the

risk that any particular child may be subject to. Recent studies do indicate that persons with disabilities are subject to sexual assault at a higher rate than persons without disabilities, one study said at more than twice the rate, and women more than men [2]. Social factors will undoubtedly play a role in predicting whether any particular person is at risk, for example, where she lives, how much exposure she has to strangers, the conditions of her home-life (whether her caregivers are biological parents, married, divorced, etc.), her own behavioral proclivities, etc. If given these factors parents determine that the possibility of assault is very remote — say, no higher than for a non-disabled woman under ordinary circumstances — then subjecting one's disabled child to burdensome measures may not be justified.

The second consideration is the level of burden that any particular procedure threatens to impose upon their child. Even if it could be legitimate to administer medications that prevent ovulation, sperm capacitation, or fertilization, the risks imposed by choosing one or another of these measures should be carefully assessed, again by undertaking proper consultation. Long-term use of powerful antiovulatory medications may be effective, but it might put the woman at risk for other serious harms. Although it is sometimes legitimate to subject oneself to more risk than is necessary, it is never legitimate to subject another, especially a small child or a disabled person, to more risk than is necessary to secure his or her well-being.

Finally, I said above that abortifacient medications should not be used. Evidence indicates that both IUDs and Plan B (the "morning after pill") can cause abortions, and so, both should be avoided as preemptive measures against sexual assault. To my knowledge vaginal diaphragms and spermicide jellies do not cause abortions.

What about ordinary oral contraceptives (OCs), do they too cause abortions? Medical literature offers conflicting answers and hence so too do pro-life physicians [3]. I will not attempt to settle the empirical question here. But I will offer my own ethical opinion. Unless we have moral certitude that the type of medication we are contemplating using will not cause abortions, and we are engaging, or likely to be subject to, behavior that may result in the fertilization of a human embryo, then we should avoid using those medications. This follows from my presumption that the absence of moral certitude means there is reasonable doubt in our mind about whether the medication might cause the death of an embryo. I would argue that we should never proceed with an act that we believe might cause some effect that, if we knew the effect would occur, would be wrong for us to cause. My advice then is that unless and until we have moral certitude, which I at least do not have, OCs should not be used as a preemptive defensive measure against possible assault from rape.

In conclusion, parents of disabled children should carefully assess whether an intervention is necessary to protect their child; and if so, determine, with the help of competent medical advisors who accept Church teaching, the least harmful morally legitimate means of achieving that protection.

Notes

[1] Catholic Bioethics and the Gift of Human Life (2nd ed., 2008), p. 220-21, italics in text.
[2] Michael Rand and Ericka Harrell, "Crimes Against People with Disabilities," Bureau of Justice Statistics

Special Report, Office of Justice Programs, U.S. Dept. of Justice, 2007.
[3] See www.prolifephysicians.org/abortifacient.htm

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