

Coercion from All Sides: The Healthcare Giver, The Patient and The Therapeutic Setting

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But whatsoever is the object of any man's appetite or desire, that is it which he for his part calleth good; and the object of his hate and aversion, evil; and of his contempt, vile and inconsiderable. For these words of good, evil, and contemptible are ever used with relation to the person that useth them: there being nothing simply and absolutely so; nor any common rule of good and evil to be taken from the nature of the objects themselves; but from the person of the man

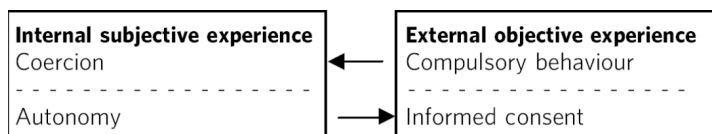
Thomas Hobbes, Leviathan



In my last essay I outlined the ways the medical industry abused the doctor patient relationship, but ignored the coercive nature of capitalism [1]. In this essay I will explore a subtle but pervasive aspect of every interaction between actor networks in the healthcare space.

One of the law's most basic questions is what is coercion? Under its traditional framing, coercion is about transactions. One person makes an offer to another person, who, under the circumstances, has no realistic option but to say "yes." But that conception has not helped courts articulate a way to test when pressures cross the line

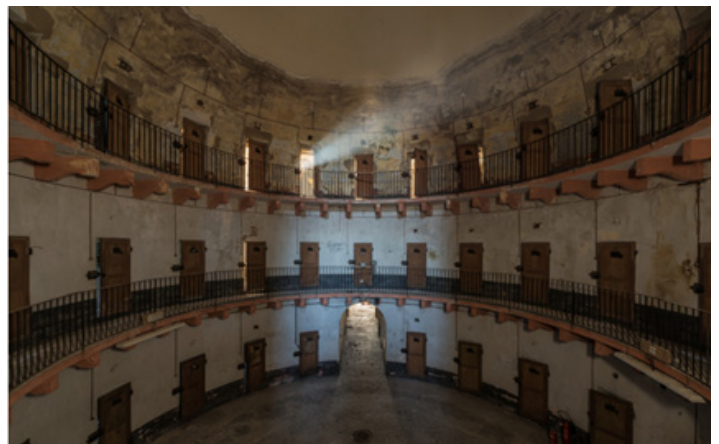
from lawful persuasion to illegal compulsion. Without a metric, critics charge that coercion analyses are inevitably normative.



Applying that to the healthcare space in which doctor, nurse and patient exist has built-in structures in place that are essentially coercive in nature.

There is, potentially, an element of coercion in every clinical encounter, and it has been argued to be an inescapable component of any human relationship.

We will analyze this from each perspective.



Panopticon, Invented in the 18th century by English philosopher and social theorist Jeremy Bentham

History

Foucault's writes in A History of Sexuality: A Will to Knowledge his theory of 'Bio-Power' which was a system of power developed during the eighteenth and nineteenth century. He defined it as,

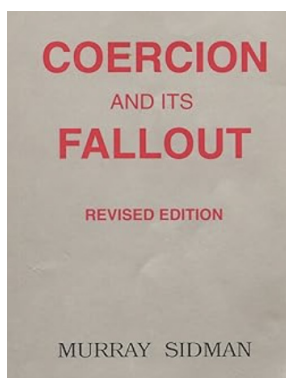
"[A] power that exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations." (Foucault, 1976 pp. 137)

Two methods were critical to this model first, came the 'anatomopolitics of the human body', which identified the body as a machine with value to be extracted if used efficiently and economically, through disciplines that make the body predictable. Foucault defined the passive and subjugated bodies that these disciplines produced as 'docile bodies', which allow the maintenance of political power.

The second was bio-power, the supervision of the birth-rate, human longevity, and mortality which helped governmental bodies cope with housing, education, and other institutions. The preservation of these power structures relied upon systems of discipline and self-surveillance as outlined in Discipline and Punish: The Birth of the Prison, using the example of the Panopticon.

The Panopticon was a prison tower designed by Jeremy Bentham that allowed full view of every cell. Each prisoner was to believe that they were under constant surveillance by this tower, whether it was manned or not.

Constant surveillance ensured the prisoners self-monitored their behaviors; the role of the guard became internalized within the prisoner as a disciplinary figure.



Murray Sidman has opened up the entire field with his research on the influence of coercion in "Coercion and its Fallout" where he extends the notion of coercion in society which is quick to use punishment to get others to do what it wants, and dog training is no exception. Are punishment-based methods of training really as quick and effective as we're often led to believe or even as they seem sometimes? Or are we lured in by the immediate result at the expense of long-term effects? This book is not about dogs, but it

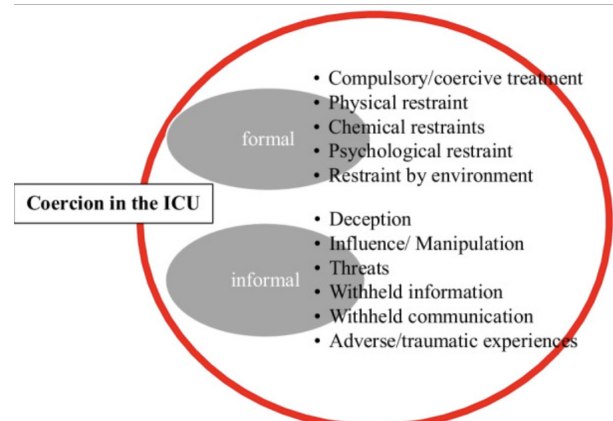
does provide some thought-provoking material in regard to our use of punishment and coercion.

When is it acceptable to use leverage to get voluntary clients to comply with treatment and how do you assure that it is not being done for expediency or other inappropriate reasons associated with the need to control the client?

We use coercion almost exclusively to control each other; many find it hard to imagine any other way. The author asks, "Does the death penalty deter potential murderers? Is harsh retaliation the answer to the discipline problem in our schools? Do the standard coercive practices work? in law enforcement, behavior therapy, education, the family, business, the armed forces, diplomacy." Behavior analysis has shown that they do not work. Coercion is in the long run self-defeating. Punishment eventually proves counterproductive. Sidman presents a rational discussion of matters in which emotions usually run strong. He proposes that what we have learned in the laboratory can provide guides both for personal conduct and public policy.

Coercion is defined as the control of behavior through: (a) punishment or the threat of punishment, or (b) negative reinforcement. The removal of punishment. The question under discussion is whether coercion is an effective and a desirable basis for applied behavior analysis. Because coercive control has always been characteristic of society in general, the problem requires consideration of all facets of our culture. Behavior analysts who use or recommend coercive techniques of therapy, behavior modification, teaching, parenting, and so on, must be viewed in that context.

In many areas of society, the practice of coercion has been refined and perfected to an extent that applied behavior analysis has never approached. Applied behavioral research therefore contributes nothing new when it applies coercive methodology. Also, coercion produces side effects that may be even less desirable than the original problem behavior. The occasional need to use coercion to deal with emergencies does not justify the advocacy of coercion as a principle of therapy.



The Patient

The prevalence of coercion in medical settings, particularly in psychiatric care, varies widely. For example, in psychiatric inpatient settings, the prevalence is often around 50%. Factors influencing these rates include the legal status of the patient (e.g., involuntary vs. voluntary admission), the type of intervention, and the specific measures used to assess coercion. It's important to note that coercion can have significant ethical and clinical implications, affecting patient outcomes and their perception of care.

Defining coercion has been a topic of interest to behavior analysts from time to time. Given the more and more subtle influence strategies that technology has enabled, it is time to revisit these definitions.

“Compulsion” in mental health care is a reasonably straightforward notion: the use of force, one hopes always governed by law, to make a person accept treatment that has been refused. The term “coercion” is usually taken to include “compulsion”, but encompasses a broader range of practices. Sometimes it is used almost synonymously with treatment pressures, including “interpersonal leverage”, and even “persuasion”.

If we are to take our thinking including research ideas forward, we need a more precise understanding of “coercion”. Most accepted is the definition proposed by Wertheimer, who includes “threats” as coercive. A “threat” is a conditional proposal (“if ..., then ...”) that, if rejected by the person, leaves him/her worse off according to a “moral baseline” (“if you refuse the medication, you will be detained in hospital”).

The moral baseline is that one is normally entitled not to be deprived of one's liberty. That is not to say that it can never be justified, but a special case needs to be made. Wertheimer contrasts a “threat” with an “offer” (or inducement). An example: “if you take the prescribed medication, you will receive a payment”. Here a rejection of the proposal does not leave the person worse off, as he/she is not entitled to a payment. Nevertheless, such an inducement can be problematic, for example, by undermining the patient's sense of agency or through corrupting the value of the treatment.



Types of Coercion

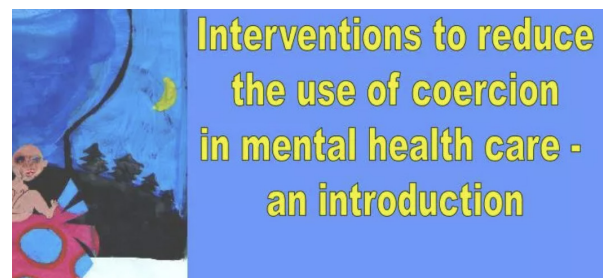
The lowest level of pressure is persuasion, in which the benefits and risks of treatment are debated but the patient's arguments are respected.

A higher level of pressure may be exerted by using an interpersonal relationship between a clinician and a patient to exert 'leverage', perhaps by expressing disapproval or withdrawing emotional support.

'Inducement' describes the exertion of a positive pressure on the patient by offering benefits, financial or otherwise, in exchange for co-operation.

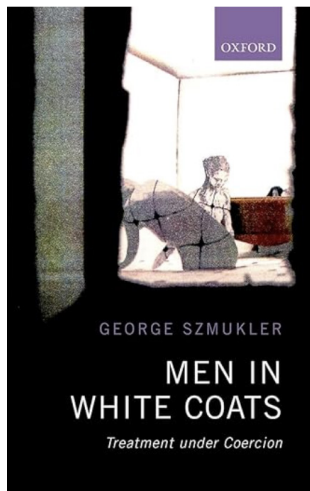
George Szmukler [2] takes coercion to cover both compulsion and threats. A further consideration is the difference between “objective” coercion and “perceived” coercion. The former follows the definitions given above. The latter is a person's perception of threat, even where no threat may be intended. A disquieting problem facing psychiatry is its “coercive shadow”, the fear many patients have that non-compliance may lead to the use of compulsion. Patients may agree to treatment, including admission to hospital, “voluntarily” to avoid the humiliation and stigma of a compulsory order. Research shows this is very common, even though in most places threats are regarded as ethically unacceptable.

Research ethics committees often struggle with research in this area. It is sensitive, and there may be concerns about consent and the “voluntariness” of participation, which may lead to bias due to the exclusion of important subgroups of patients. With careful thought these problems can be overcome.



A huge challenge to involuntary treatment comes from the United Nations (UN) Convention on the Rights of Persons with Disabilities. By April 2015, 159 states were signatories. The elimination of discrimination by ensuring that rights may be enjoyed “on an equal basis with others” is a fundamental aim. Persons with serious mental illness are considered by the UN Committee for the Rights of Persons with Disabilities, the authoritative body set up by the UN to interpret and monitor compliance with the Convention, to fall under the characterization of “disability” (sometimes referred to as “psychosocial” disabilities).

Szmukler argued that conventional mental health law discriminates against persons with a mental disorder since it does not respect such persons' autonomy (or rights to self-determination or self-governance) in the same way as in the rest of medicine. In the latter, considerations such as impaired “decision-making capacity” and treatment needing to be in the person's “best interests” justify the over-riding of a treatment refusal.

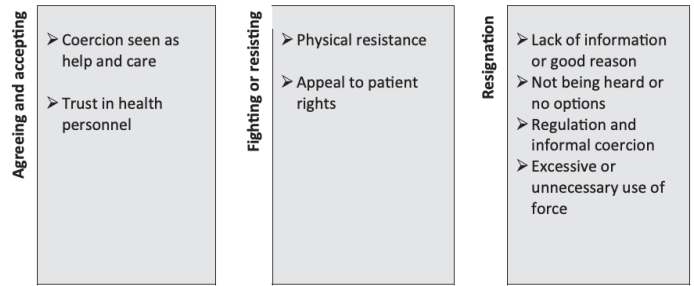


In the mental health field, a diagnosis of a “mental disorder” usually vaguely defined and the presence of some kind of risk to self or others comprise the criteria. The rules are entirely different. Furthermore, the “protection of others” permits the preventive detention of persons with mental disorder on the basis of the risk they are deemed to pose before they have actually committed an offence. This group is unique in this regard. The many more persons without a mental disorder who are equally or riskier are not liable to such detention. In this regard, non-discrimination means either having generic “dangerousness” legislation equally applicable to all who present an unacceptable level of risk, or no preventive detention for anyone. There is reasonably consistent evidence, even when involuntary treatment has been authorized, that “perceived coercion” is less when the relationship between patient and clinicians is good, and when patients believe their “voice” has been heard.

Does describing a traumatic experience of coercion automatically lead to the conclusion that the coercive act was morally wrong? Many express strong criticism of the use of coercion in mental health care, while others argue that its use is ethically acceptable when the ‘benefits’ with regard to protection or treatment outweigh the ‘negative effects’ on patients’ autonomy, integrity and comfort [3,4].

The use of coercion in mental health care should never be normal or self-evident; however, there is no real consensus about correct practice or the right moral justification of coercion. Why has it become so controversial? Coercive treatment often arises out of complex situations. Coercion can also be justified by different legal, clinical and ethical arguments [4]. Furthermore, patients, families and clinicians have different perspectives of suffering and care [5]. The dilemmas of clinical assessments thus become as diverse as the principal discussion.

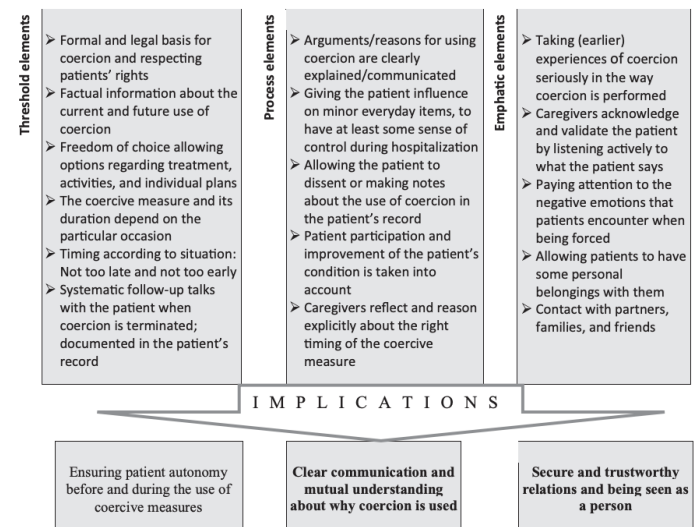
Geir F. Lorem, Marit H. Hem, and Bert Molewijk write that there are types of “good coercion” and found that patients differentiated implicitly between experiences and moral evaluation [6].



They determine findings have been ordered into three types of reactions: agreeing and accepting, fighting or resisting, and resignation.

Further reflection upon patients’ positive and negative moral evaluations of coercion resulted in the formulation of different concrete elements at three levels: threshold elements, process elements, and empathic elements. These elements helped them to understand what these patients considered ‘good coercion’.

This study fails to determine to what extent the patient wishes to please the physician as an unconscious bias in his moral decision making.



Emanuele Valenti and Domenico Giacco identified characteristics within the range of influence strategies used in community care that differentiate “non-coercive” from “coercive” influence strategies [7].

Influence strategies such as persuasion and interpersonal leverage are used in mental health care to influence patient behaviour and improve treatment adherence. One ethical concern about using such strategies is that they may constitute coercive behaviour (“informal coercion”) and negatively impact patient satisfaction and the quality of care. However, some influence strategies may affect patients’ perceptions, so an umbrella definition of “informal coercion” may be unsatisfactory. The latter is characterized by using a lever, expressing clinical decisions as conditional offers and not allowing patients free choice about therapeutic proposals. Their findings

provided empirical validation and specification in the practice of theoretical frameworks on coercion in mental health care.



The characteristics differentiating “non-coercive” and “coercive” influence strategies can be used to facilitate and standardize reflection on influence strategies in community mental health care.

Even though conditionality is defined in the mental health literature referring to both conditional and biconditional statements, what is relevant to understanding is the relationship between that concept and the type of choice. The findings show two different types of choice, one depending on what patients have in mind and their ideas about the aims and consequences of the therapeutic offer and the other built upon a patient’s awareness of their clinical circumstances.

In the case of the former type of choice, the provider client relationship is not based on trust and motivation but rather on manipulation and deceit and is in the patient's best interests. The latter is an informative process whereby patients provide an assessment focused on reciprocity and confidence and aim to define a therapeutic agreement.



The Physician

The coercive effects on the treating physician come from many different sources, rather than in the interests of the therapeutic outcome as above.

The agencies governing his behavior his practice (allopathic homeopathic osteopathic chiropractic etc.) force him to restrict the choices he can make in treatment strategies based on conventions rather than evidence based scientific data. In addition, the notion of medical “ethics” has more to do with the protection of the particular

club he belongs to and the non-violation of turf of another society of practitioners.

Coercion in Medical Practice from Agencies or Institutions:

1. Conflict between patient autonomy and perceived clinical duty: There is often tension between respecting a patient's right to make their own healthcare decisions (autonomy) and what healthcare providers believe is in the patient's best medical interest (beneficence).
2. Informal coercion: Healthcare professionals may use subtle forms of pressure or leverage to influence patients' decisions without formal coercive measures. This can include persuasion, inducements, or threats.
3. Institutional pressures: Healthcare workers may feel pressured by their institutions to use coercive measures to achieve certain outcomes or metrics. This can conflict with their ethical obligations to patients.
4. Power imbalances: There are inherent power differentials between healthcare providers and patients that can enable coercion, especially for vulnerable populations.
5. Resource allocation issues: Limited resources may lead to coercive practices to ration care or transfer patients inappropriately ("turfing").
6. Lack of clear ethical guidelines: While there are general principles like respecting autonomy, there is often a lack of clear guidance on navigating complex situations involving potential coercion.
7. Tension between individual and public health: In some cases, coercive measures may be seen as justified for public health reasons, creating ethical dilemmas.
8. Inadequate informed consent: Coercion can undermine true informed consent if patients are not given full information or feel unduly pressured.
9. Violation of professional ethics: Coercive practices may violate core medical ethics principles and damage the patient-provider relationship.
10. Legal and regulatory concerns: Healthcare institutions must navigate laws and regulations around involuntary treatment, while also addressing ethical issues.

The key challenge is balancing respect for patient autonomy with other ethical principles and practical constraints in a way that minimizes inappropriate coercion while still providing necessary care. This requires careful ethical reasoning and clear institutional policies.



to fears of regulatory action.

2. The Pain Relief Promotion Act of 2000 aimed to promote pain management and palliative care while prohibiting assisted suicide. It specified that using controlled substances to alleviate pain, even if it may increase risk of death, is a legitimate medical purpose consistent with public health and safety.

3. There are legal and ethical obligations for physicians to provide adequate pain relief. Denying access to pain management can potentially be interpreted as constituting inhuman or degrading treatment from a human rights perspective.

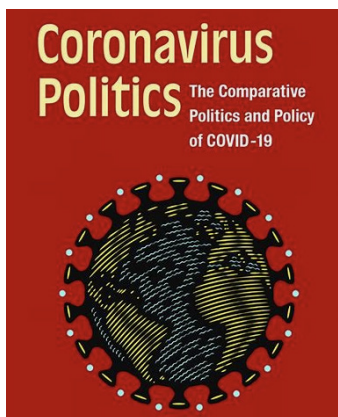
4. Regulatory bodies and professional societies have encouraged or mandated the use of controlled substance agreements for patients on long-term opioid therapy. While intended to improve safety and adherence, some argue these can be stigmatizing or coercive if not implemented properly.

5. There is an ongoing tension between efforts to reduce opioid misuse/diversion and ensuring appropriate access for patients with legitimate pain needs. Overly restrictive policies could be seen as a form of indirect coercion limiting pain treatment options.

6. Physicians have ethical obligations to relieve suffering, but must balance this with concerns about regulatory scrutiny of prescribing practices. This can create challenging situations when deciding how to manage patients' pain.

7. Any policies or actions by government agencies that unduly restrict legitimate pain management practices could potentially be viewed as coercive, even if not explicitly intended as such. However, reasonable regulation to promote safe prescribing is generally accepted.

In summary, while there are valid public health and safety concerns around opioid prescribing, overly aggressive or inflexible regulatory approaches have the potential to indirectly coerce physicians away from providing appropriate pain care in some cases. Balancing pain management with abuse prevention remains an ongoing challenge. Coercion plays the most important way of restricting physicians and has radically altered the way they prescribe at to detriment of patient care.



Public Policy and Coercion

The COVID-19 pandemic has challenged governments around the world. It also has challenged conventional wisdom and empirical understandings in the comparative politics and policy of health. Three major questions present themselves:

First, some of the countries considered to be most prepared-having the greatest capacity for outbreak response-have failed to respond effectively to the pandemic. How should our understanding of capacity shift in light of COVID-19, and how can we incorporate political capacity into thinking about pandemic preparedness?

Second, several of the mechanisms through which democracy has been shown to be beneficial for health have not traveled well to explain the performance of governments in this pandemic. *Is there an authoritarian advantage in disease response?*

Third, after decades in which coercive public health measures have increasingly been considered counterproductive, **COVID-19 has inspired widespread embrace of rigid lockdowns, isolation, and quarantine enforced by police.** Will these measures prove effective in the long run and reshape public health thinking?



Quarantine was experienced as burdensome by participants. Shortcomings in social support, everyday necessities, information, hygiene, and daily activities exacerbated the strains of quarantine. Interviewees held different opinions about the usefulness and appropriateness of the various containment and mitigation measures. These opinions differed by individual risk perception and the measures' comprehensibility and compatibility with personal needs. The imposition of mass quarantine defined as indiscriminate restrictions of within and in-and-out movement for all inhabitants of collective accommodations was recurrently implemented in US and other countries [8]. However, the psychosocial consequences of pandemic measures, which primarily aim to safeguard physical health, needed to be considered as well. It is known that quarantine and isolation can negatively impact mental health in general.

Katrin Schmelz has described how government mandated enforcement may crowd out voluntary support for COVID-19 policies, especially where trust in government is weak and in a liberal society. Most anti COVID-19 policies share the fundamental structure of public goods dilemmas where all-encompassing cooperation maximizes the well-being of all citizens, but since cooperation is costly each individual has an incentive to free ride on others' cooperation. Experiments with public-goods games around the world have shown that in the absence of punishment of free riding substantial levels of initial cooperation typically

decline as contributors become discouraged or angered by those not contributing [9]. According to a large literature on cooperation and punishment, people expect enforcement to ensure higher cooperation in the population. For example, the belief that most others will cooperate encourages conditional cooperators to do the same [10-12]. This suggests that average agreement to follow anti COVID-19 measures should be higher if a measure is enforced than if it remains voluntary.

On the other hand, enforcement and incentives can reduce intrinsic motivation, a phenomenon termed “motivational crowding out.” Evidence was provided by psychologists decades ago under the umbrella of “self-determination theory,” distinguishing between autonomous and controlled motivation [13,14]. More recently, this phenomenon has also been emphasized by political scientists and found in behavioral experiments by economists [15-17]. The possibility that the effectiveness of an enforcement-based approach might be compromised because it crowded out voluntary commitment has also been termed “control aversion”.

There is evidence that the frequency of control-averse types varies across populations and that control aversion can be identified in neuropsychological correlates [18].



Coercion of the Hospital/Clinic affecting doctor patient space

Medical ethics is supposed to serve as a moral compass. Others call upon the field to be edifying and to provide guidance. Instead, medical ethics frequently muddies the waters and points people in the wrong direction.

The ‘best interest standard’ is a case in point. It is widely invoked in medical ethics as the criterion for clinical decisions and clinical behavior. Nevertheless, clinicians who have more than one patient and more than one responsibility are frequently not acting in the patient's best interest. Imagine a bleeding accident victim brought into a crowded emergency room. When a physician attends to this patient's urgent needs before seeing the patient who arrived earlier with less urgent needs, we believe the physician is doing the right thing, although she is not acting in the best interest of the patient who is left to wait longer. When multiple patients require medical resources or attention, some patient's best interest has to be sacrificed for the good of another. We learned this in our medical regiment during triage training. Someone always pays the price because of lack of resources structurally inherent in the system. When achieving educational goals requires some extra examination or practice by someone low down on the learning curve, again, the patient's best interest is sacrificed. When research goals require extra tests or extra time, again, the patient's best

interest is sacrificed. Although the patient's interests must always be considered, and clinicians must always strive to achieve optimal outcomes for each patient, often good clinical practice does not actually reflect every patient's best interest. Using ‘best interest’ language is inaccurate, and it presents a distorted picture of what medicine is and should be.

The doctrine of double effect and the killing and letting die distinction are more glaring examples of misdirection originated by medical ethicists. When medical ethicists promote a simplistic understanding of these concepts as principles of medical ethics, their inaccuracy encourages people to accept fallacies as truths. The entire direction of the hospice movement changed from an initial benign offering of care without the onerous acute care operating actor networks to a humanistic approach to death and dying, now doctors were insisting on hospice care in the interest of cost containment despite the religious cultural or ethnic objections of the family.

Patients have specific rights that are meant to protect them from abuse, neglect, or coercion. The Centers for Medicare & Medicaid Services (CMS) emphasizes that hospice patients have "the right to be free from abuse, neglect, mistreatment, and deserve to have their personal property kept safe". This underscores the importance of respecting patient autonomy in end-of-life decisions.



Informed Decision-Making: Hospices/End of Life

For a decision to enter hospice to be truly autonomous, patients must be fully informed about their options. This includes:

- Understanding the nature of hospice care and what it entails
- Being aware of alternatives to hospice
- Having accurate information about prognosis and disease progression
- Being free from external pressure or coercion

Healthcare providers have an ethical obligation to ensure patients have all the necessary information to make an informed choice about hospice care.

While outright coercion may not be evident, there may be more subtle forms of pressure that can influence a patient's decision:

- Financial considerations, especially given the high costs of continued curative treatment
- Family members who may push for hospice care due to

caregiver burden

- Healthcare systems that may have incentives to move patients to hospice care

It's important for healthcare providers to be aware of these potential influences and work to mitigate them in the decision-making process.

Several safeguards exist to protect patients from coercion regarding hospice care:

- Hospices are required to immediately report and investigate any alleged violations of patient rights
- Patients have the right to leave hospice care at any time if they change their mind
- Medicare's Hospice Compare tool allows patients and families to research and compare hospice providers

Examples of Coercion Inside Hospices Include:

- **Verbal abuse:** Includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability
- **Mental abuse:** Includes humiliation, harassment, and threats of punishment or deprivation
- **Sexual abuse:** Includes, but isn't limited to, sexual harassment, coercion, or assault
- **Physical abuse:** Includes, but isn't limited to, hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment
- **Neglect:** Means failure to provide goods and services necessary to avoid physical harm or mental anguish.

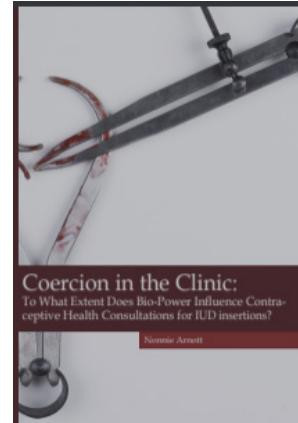


Doug McConnell and Grant Gillett have explored the concept of coercion within therapeutic communities. In their work, they emphasize that coercion is a pervasive and necessary aspect of society and conscious life. They use Foucault's idea of 'discipline' to illustrate how social structures guide individuals into specific ways of living [19].

Their research suggests that therapeutic communities play a crucial role in helping individuals who have been adversely affected by societal pressures. By educating patients about the community's transformative goals and mediating conflicts professionally, these communities aim to prepare individuals for reintegration into society [19].

Recently the therapeutic community (TC) has become the focus of a new optimism especially in treating holistic social problems such as personality disorder.

However even in therapeutic communities (TC) the concept of coercion is at the crux of all ethical and functional questions facing it and wider society. The TC's ostensible role is to heal those who have been damaged by life in wider society and who will continue to struggle without the TC's discipline. This extra discipline should be offset by educating patients about the TC's transformative aims and professional mediation of resulting conflicts.



Wider society lacks explicit education about coercive influence and mediation is not always sympathetic. However, it is this deceptive environment that patients aim to return to.

Thinking back to the last time a healthcare provider talked to you about birth control, did you experience any of the following? Please select all that apply.

**Downward
Contraceptive
Coercion:
Pressure
to not use
contraception**



- The healthcare provider would not give me the birth control method I wanted.
- The healthcare provider made me feel that I should not use birth control.

**Upward
Contraceptive
Coercion:
Pressure
to use
contraception**



- The healthcare provider made me keep using a birth control method that I wanted to stop using.
- The healthcare provider made me feel like I had to use birth control.
- The healthcare provider made me use a specific birth control method.

Women more Vulnerable to Coercion

In another example Nonnie Arnott describes to what extent power influences physicians and patients regarding their reproductive health.

Again using Foucault's theory of bio-power, the development of clinical terms creates an unbalanced patient-doctor power dichotomy, this authoritative knowledge is imposed upon the reproductive body. Foucault's theories can be applied to contemporary contraceptive health, particularly with the doctor-patient relationship and the informed consent model.

Contraceptive options are explained through a model of 'informed consent' whereby the clinician must make the patient aware of the risks as well as the benefits of procedures and treatments. This was designed to allow autonomy and self-determination for

the patient to make educated decisions. As this model interacts with hierarchical medical practices, patient choice is overridden in favour of medical knowledge. Furthermore, this knowledge, taught by the professional to the patient serves to create self-surveillance and adherence to regimen that results in control over the internal reproductive system. Prevalent in western society is the social stigma against teen pregnancies and those who become pregnant without a partner. The presumption is that by preventing childbirth, there are more opportunities to advance through career paths and therefore improve quality of life as per capitalist society.

By advising against less effective forms of contraception, clinicians reinforce the disciplinary figure through these notions, and the patient internalizes self-surveillance to avoid disapproval.

This essay outlines the form coercion takes: overt as well as subtle, in the healthcare space affecting both doctor and patient.

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