

**A BIOETHICS APPROACH TO EXAMINING INADEQUATE ACUTE PAIN
CONTROL DURING INTRAUTERINE DEVICE INSERTION**

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Abstract

Intrauterine device (IUD) insertion procedures can cause pain, where some patients even have an extreme level of pain. This is a health care problem that should prompt further questioning and ethical analysis. While ethics-related concepts have been described in the literature surrounding IUD insertion procedures, there is a shortage of explicit ethical analysis through the use of ethical principles. The purpose of this thesis is to illustrate how bioethics concepts, such as beneficence, nonmaleficence, respect for autonomy, and justice, can serve as a useful lens for examining issues related to pain with IUD insertion procedures. In this analysis, concerns with IUD insertion procedures are grouped and analyzed through the perspective of each ethical principle. Additionally, it is possible to examine how ethical principles conflict with each other within the space of IUD insertions. By assembling a comprehensive review of IUD insertion pain issues through the language of ethics, this thesis brings this reproductive health problem further into the academic bioethics sphere, highlights how the current handling of IUD insertions is ethically problematic, and argues why bioethics should dedicate space and consideration to this topic.

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Introduction

The issue of acute pain experienced by women¹ during intrauterine device (IUD) insertion is ethically complex and warrants consideration from a bioethics perspective. The purpose of this analysis is to perform an overarching examination of the state of pain control for IUD insertion through an ethical lens and illustrate how the current circumstances surrounding pain management for this procedure are both ethically complicated and ethically problematic. A number of ethical concerns arise within the context of Beauchamp and Childress's (2019) established principles of beneficence, nonmaleficence, respect for autonomy, and justice. Ethical concerns further manifest from tensions between these ethical principles regarding IUD insertion procedures.

There are substantial reasons why acute pain during insertion and the handling of that pain deserve to be evaluated in more detail, and I will begin by establishing background considerations to understand the scope of current pain control practice and pain experiences in order to justify the ethically-grounded scrutiny. Following this overview, I will review insertion-pain related concerns raised in both the popular and academic literature and explain how they map onto the ethical principles of beneficence, nonmaleficence, respect for autonomy, and justice. My hope is that by overlaying ethical principles onto a summary of previously-described concerns regarding acute insertion pain, there can be a broadened academic dialogue that helps us recognize and appreciate this for the ethical issue that it truly is.²

In following Johns Hopkins Berman Institute of Bioethics (n.d.) *Program on Ethics in*

¹ To note: Much of the literature included in this review groups patients into the category of "women." I will be using this language with the understanding that it is not inclusive of everyone who could be getting an IUD.

² See a similar, more general argument about bioethics and pain extrapolated in Carvalho et al. (2018) *Ethical decision making in pain management: a conceptual framework* <http://dx.doi.org/10.2147/JPR.S162926>

Clinical Practice: Stepwise Approach for Addressing Ethics Issues, after laying the groundwork for some major clinical and ethical problems related to the lack of effective IUD insertion pain control, I will explore ethical dilemmas that arise between competing principles and stakeholders within this arena. One ethical conflict, described primarily by Pierson (2021) in her article *Disclosing Pain: The Case for Greater Transparency*, derives from how clinicians and patients may differently weigh respect for autonomy against obligations to beneficence and nonmaleficence when making decisions about informed consent. Separate tensions emerge in our interpretation of the relationship between IUD access and IUD insertion pain control, where, in this sense, access is examined in conversation with pain control. The intent of situating these conflicts is not necessarily to resolve them, but rather to understand how the questions and nuances they raise support the continued discussion of and attention to women’s experienced pain during this procedure. I conclude by examining ethical questions and obligations which derive from this issue and highlighting future research directions that can make this procedure more ethically acceptable. Ultimately, this analysis will illustrate how a principlist framework of ethics can be helpful in drawing attention to the issue of inadequate pain control during IUD insertion procedures and working through ethically-dense challenges that emerge as a result.

Section 1

Background

First and foremost, within a clinical context, there are clear issues in our understanding of and approach to planning for the control of procedural pain: Almost as a metaphorical shoulder shrug, one study notes that there is “no accepted standard for prevention or treatment of [severe pain]” (Gemzell-Danielsson et al., 2013, p. 423), with a review reporting insufficient pharmacological support targeting this procedure (Nguyen et al., 2020, p. 1144). Similarly,

scientifically-grounded directives for managing IUD insertion pain are sparse (Bahamondes et al., 2014, p. 54), and Smothers (2018) identifies “a gap between what the science says is true and what women say is true about IUD insertion pain management” (para. 20), with discrepancies between research and felt pain (para. 6, 20).

The primary message is that there exists “no comprehensive strategy...for managing pain associated with the insertion of IUC [intrauterine contraception]” (Gemzell-Danielsson et al., 2013, p. 420) *despite the fact that* “many, particularly nulliparous patients, report moderate to severe pain” (American College of Obstetricians and Gynecologists [ACOG], 2023a, 0:22) during insertion. Effective pharmacology could improve experiences with pain for a non-negligible number of patients (Gemzell-Danielsson et al., 2013, p. 425). Ultimately, placing this clinical issue within an ethics framework generates questions about ethical obligations for pain control efforts.

The ethical principles of beneficence, nonmaleficence, autonomy, and justice offer a lens for analyzing IUD insertion pain in a practical context. Here, the primary focus will be centralized around the patient and guided by Beauchamp and Childress’s (2019) principles: beneficence, as it relates to the patient’s well-being; nonmaleficence, as it relates to refraining from harming the patient; autonomy, as it relates to respecting patients as humans with individual decision-making capacity; and justice, as it relates to considering what is fair and equitable for patients. Each of the following sections examines how factors within the context of painful IUD insertions can be categorized by and raise concerns across all four of these bioethics principles.

Beneficence and Nonmaleficence

The principles of beneficence and nonmaleficence demand that providers do what is best

for their patients so as not to harm them unjustifiably (Beauchamp & Childress, 2019). However, evidence reveals that the way our medical system performs the procedure of IUD insertions does not clearly satisfy these duties. In a straightforward sense, people can experience pain when receiving an IUD (Mody, NCT02219308). A study of nulliparous women in Sweden even recorded that 17% of their participants found the insertion experience to be “severely painful,” with 72% reporting it as “moderately painful” (Marions et al., 2011, p. 126). That such a sweeping volume of patients had considerably painful ordeals should raise red flags. Anecdotal evidence from online news articles echoes this data, while also revealing a more comprehensive story with women disclosing how they made their doctor stop the insertion before it was completed (Cauterucci, 2015) or rate their procedure “as ‘hell on earth’” (Kitchener, 2021, para. 8). It raises the overarching question, “Are we acting in the most beneficent way possible toward patients?” Relatedly, Gemzell-Danielsson et al. (2013) claim that particular care and consideration must be given to those for whom the procedure causes serious pain (p. 423). As described by Nudson (2022), causing this level of pain can have significant implications for patients when it comes to their own healthcare, highlighting that broad gynecological procedural pain and negative care encounters impact downstream health care, where “bad experiences can lead to avoiding care entirely” (para. 16). Because IUD insertions cause notable adverse encounters, it can be illuminating to think about the degree to which the procedure aligns itself with obligations to patient well-being and against harm. Would acting in alignment with beneficence require that “all patients be entitled to some ‘bare minimum’ of pain relief services?” (Sullivan, 2000, pp. 278-279) Overall, by applying ethical principles of beneficence and nonmaleficence to this clinical care issue, we broaden the scope of dialogue in a way that will hopefully expand the reach of these data and stories, particularly amongst an audience of

providers, ethicists, students, and policy makers who are in positions to enact change.

Respect for Autonomy

Respecting the autonomy of patients as decision-makers in their own health care is a critical component of all clinical practice. Under the umbrella of autonomy exists the obligation to collect informed consent from patients, where informed consent is expected to involve enough information and be both comprehensible and voluntary on behalf of the patient (Beauchamp & Childress, 2019). However, an informative piece by Pierson (2021) surrounding IUD insertion procedures introduces notable points of concern in how the principle of autonomy is upheld in practical clinical actions: She raises a glaring issue in how physicians present and frame possible pain during the procedure, writing that, “if clinicians believe a procedure is in a patient’s best interest, they may downplay the pain associated with it to increase a patient’s likelihood of giving consent” (para. 5). Pierson (2021) goes on to say, therefore, that if an IUD constitutes best interest, the tactic of downplaying could be employed to promote IUD selection (para. 10), even though a lack of comprehensive conversations about pain control can have negative implications for “undermining trust” in the therapeutic relationship, “compromising the validity of consent, and undertreating pain” (para. 15). Physicians making the decision to do as Pierson (2021) says and purposefully “misleading patients” (para. 8) about the procedure constitutes a violation of the principle of autonomy through a deliberate curtailing of the patient’s access to information. Pierson (2021) provides a helpful example for visualizing the direct relationship and ultimate disconnect between the provider’s possession of authority and the patient’s possession of ultimate autonomy. Several popular articles describe instances where women are not given satisfactory warnings by their clinical team about how much pain they could experience during insertion (Kitchener, 2021; O’Donohue, 2021; Lucy Cohen, as quoted in PatientSafetyLearning

Team, 2021), suggesting that “true informed consent” was not received before proceeding (O’Donohue, 2021, para. 9). Through our understanding of the principle of autonomy laid out by Beauchamp and Childress (2019), it follows that inadequate informed consent violates the imperative to respect patient autonomy laid out by the ethical principle. Therefore, in order to come to an informed decision about what to do, “there needs to be a thorough explanation of the procedure,” says patient Lucy Cohen (PatientSafetyLearning Team, 2021, What needs to happen section). Highlighting how clinical interactions titrate and cherry-pick consent-related information exposes this component of the IUD insertion procedure as ethically problematic.

Pierson (2021) raises another issue connected to the maintenance of autonomy during this procedure in the context of provider interpretation, perception, and underestimation, and she makes reference to a study by Maguire et al. (2014) which documents that “providers significantly underestimate pain during IUD insertion” (p. 23). Research by Akintomide et al. (2015) references and corroborates the Maguire et al. study and documents how there was a statistically significant difference between patients’ pain and the pain providers identified. This is significant for informed consent and downstream consequences for trust in the therapeutic alliance if the pain patients have surpasses what they were forewarned about (Pierson, 2021), as well as for how providers will inform patients about pain before the procedure (Maguire et al., 2014, pp. 23-24). Ultimately, there are complex dimensions to how our understanding of respect for autonomy functions within IUD insertion procedures. But, literature highlights clear ethically-questionable components to how communication about this procedure is currently handled.

Justice

Within bioethics, justice is generally characterized by a commitment to fairness and an

absence of inequity (Beauchamp & Childress, 2019). However, this obligation to justice is markedly unfulfilled within the space of pain control for IUD insertion. Ethically-based challenges to the current status of the procedure can be examined amongst a broader justice problem that, according to public figure Naga Munchetty, exists within a greater scope of views and opinions on women's pain (Wade, 2021). Miller (2022) documents that "there isn't a large body of research measuring pain from invasive gynecological procedures" (Pain burden section). Of consideration to the ethical principle of justice (and to a broader observation of how this principle is violated by medicine's approach to IUD insertions) is something Bever (2022) names as "pain bias," which describes a common thread of disregard when women bring issues related to their reproductive health and IUDs to the forefront (Reproductive health complaints section), and where frequently, instead of getting relief during a painful insertion, instead there are "feeling[s of being] ignored or overlooked by health-care providers" (Kitchener, 2021, para. 9). Any clinical procedure or practice that operates like this is, simply, not fair nor equitable and reflects injustice at the personal and provider levels. Another serious justice violation is documented among a subset of patients, noted in the fact that "Black adolescent women experience greater anticipated pain with IUD insertion" (Hunter et al., 2020, p. 27). This inequity contradicts our expectation of justice by singling out a patient population that is worse off, thus illustrating an ethically-problematic characteristic of present IUD insertion procedures.

A related issue is raised by one blog post related to IUD insertion pain, which describes how pain control is frequently titrated based on "the assumption that everyone will have a largely pain-free experience" (Yoppie, 2021, Painful for some section). If we are not treating patients equitably or fairly, this constitutes a justice issue. One way to begin addressing this concern is to possibly "reduc[e] the threshold for local anesthetic use," particularly for the sake of nulliparous

patients with severe pain during insertion (Brima et al., 2015, p. 25). Additionally, having some type of anesthetic available as a standard (which would address the “unpredictab[ility]” of insertion pain) is the hope shared by Dr Melanie Davis-Hall (Wade, 2021, para. 10). It is worth considering if and how these propositions for pain control would be a positive step toward fulfilling justice-derived obligations.

Ultimately, the use of ethical principles to examine reported pain and processes related to IUD insertion procedures provides a framework from which to evaluate them. Popular and academic literature have already illuminated pressing ethical concerns; however, this review attempts to organize and evaluate them through a comprehensive and explicit ethical lens. Beneficence, nonmaleficence, autonomy, and justice can function in conceptualizing what is troubling about IUD insertions and inform considerations of where we need to go in the future.

Section 2

Overview of Conflicts

Now that I have established an overview of some major ethical concerns related to pain caused by IUD insertions, the next step in the Johns Hopkins Berman Institute of Bioethics (n.d.) *Program on Ethics in Clinical Practice: Stepwise Approach for Addressing Ethics Issues* is to examine how the ethical principles come into conflict with each other to create practically-relevant ethical dilemmas involving patients and their providers.

Respect for Autonomy vs. Beneficence/Nonmaleficence

Based on the existing literature about pain during IUD insertion procedures, there appears to be an interesting conflict that emerges between the principles of autonomy, beneficence, and nonmaleficence. Because this general type of conflict is so blatant, the American Medical Association (AMA) Code of Medical Ethics (n.d.) explicitly recognizes the ethical dilemma to

be addressed, writing that “withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated creates a conflict between the physician’s obligations to promote patient welfare and to respect patient autonomy” (Withholding Information section).

This conflict has been previously explicated in the context of IUD insertion procedures by Pierson (2021), who has outlined the contradiction between not disclosing possible pain to minimize procedural pain, but then having patients be unprepared for the amount of pain they have because their provider underestimated it. My goal in following the framework of Pierson’s summary is to situate her flagged arguments within a broader review of ethical issues related to IUD insertion pain.

To begin, I will draw back to a striking point made by Pierson (2021) regarding the physician’s choice to “downplay[] expectations” in order to “reduce pain,” which she says can “justify[] not disclosing how painful a procedure is for patients who do not want to know” (para. 7), wherein she illustrates this justification stems from ample research evaluating the connection between anxiety about the procedure and experienced pain. For example, Gemzell-Danielsson et al. (2013) and Bahamondes et al. (2014) report a positive correlation with anxiety and pain, wherein preceding anxiety can consequently spell more perceived pain, with additional research corroborating that the more people anticipate pain before the IUD is inserted, the more likely they will be to have pain (Dina et al., 2018, p. 236.e8; Hunter et al., 2020, p. 27). Here, anxiety and anticipated pain appear to function in similar ways in how they lead to more procedural pain. Taken together, we get a deeper sense of how physicians appeal to this belief that they are contributing to the well-being of their patient and refraining from harming them (i.e. adhering to their obligations to beneficence and nonmaleficence), which can be rationalized (Pierson, 2021). Because not informing a patient of how much the insertion will hurt could help them feel less

pain and also consent to what the physician believes is a favorable IUD, from a physician's perspective therefore, it appears there may be an impetus to prioritize obligations to beneficence and nonmaleficence over autonomy (Pierson, 2021).

There is anecdotal evidence from the patient perspective that enables us to visualize how the conflict between ethical principles manifests in practice: A study by Schmidt et al. (2015) collected qualitative data related to IUD insertion procedures and describes a repeatedly-mentioned desire for greater details, even directly quoting a patient who said ““You did tell me but...I did not know it was going to be this bad!”” (p. 385) In an interview with a patient named Lucy Cohen, she conveys how, in getting her IUD and having severe pain, she “most certainly did not consent to be in that much pain” (PatientSafetyLearning Team, 2021, What needs to happen section). Another patient reported to a friend that she was not told about the seriousness of the pain (Peck, 2019). The ethical conflict lies herein: On one hand, providers are acting in ways that reflect what they see upholds their obligations to beneficence and nonmaleficence by trying to decrease the probability of pain, while, at the same time, patients reporting much more pain than they have been told about thus raises concerns about providers' commitment to their autonomy (Pierson, 2021). As O'Donohue (2021) conveys in her popular article, without fully informed consent and adequate preparation for possible severe pain, patients are not able “to weigh things up and make the choices that feel right for them” (para. 10). The reality of this ethical deliberation stands at the forefront of how providers like Dr. Eve Espey – who focuses on long-acting reversible contraception (LARC) and leads that division at ACOG – approach IUD insertions: She recognizes the association between anxiety, pain, and her role in briefing patients about it, but also yields in favor of honesty concerning procedural side effects (Smothers, 2018, para. 18). Thus, we are still left to consider the two separate sides of this conflict that Pierson

(2021) has explicated and Espey has confirmed exists in the clinic (Smothers, 2018): Do not inform the patient of the full scope of pain in the hopes of reducing possible pain (thus acting with beneficence and nonmaleficence) versus recognizing how duties to autonomy demand informed consent that affects individual patient decision-making. This tension implies ethical questions about harm and good: Are physicians doing more harm, ethically speaking, to their patients by informing them of the entire spectrum of pain for this procedure and potentially causing anxiety? Or is it worse, ethically speaking, to not tell patients as a protective measure and instead risk violating their autonomy?

Putting professional literature from ACOG into conversation with requirements set forth by the AMA, it seems, at first, that they corroborate the patient perspective when it comes to potential pain disclosure. Instructions from ACOG (2023b) straightforwardly posit that providers must “review the pertinent risks with every patient, including pain with and after insertion” (0:45) and gather informed consent that includes “a thorough discussion of risks, benefits, alternatives, and expectations with use” (0:39). The AMA (2012) also maintains that it is “ethically unacceptable” to knowingly “withhold[] medical information” (p. 555). Additionally, because of the connection between anxiety and increased pain, “verbal anesthesia” and adequate counseling are also discussed (Gemzell-Danielsson et al., 2013, p. 425). Interestingly, however, both the AMA (2012) (generally speaking) and Pierson (2021) (within the context of IUD insertions) suggest that it is acceptable to titrate information sharing based on patient preferences. Such a qualification – derived from the conflict between autonomy and beneficence/nonmaleficence – demonstrates an explicit way in which the clear ethical dimensions surrounding IUD insertion procedures and their associated pain and informed consent become twofold and muddled in a manner that may further fail to afford providers a

clear, ethically-aligned set of steps for preparing to insert an IUD. A nuance extrapolated in a larger conversation about pain management by Sullivan (2000) follows that there is not always an alignment between autonomy promotion and respect, therefore prompting an exploration of what it means, in practice, to respect patient autonomy regarding IUD insertion procedures when one understanding of autonomy defers to patient choice and another perspective is that they need more extensive details to make a fully-informed decision. In considering specific situations, for example, OB/GYN physician and professor Dr. Maria Rodriguez describes how she approaches patients with past trauma as having a conversation ““about what they need to feel comfortable and safe”” during the IUD insertion procedure (Pearson, 2022, Anxiety question section). A trauma-informed approach can greatly promote patient autonomy in a comprehensive way (Harris, 2022), and ACOG’s Committee on Health Care for Underserved Women (2021) recommends “universally implement[ing]” (Recommendations and Conclusions section) this model to provide patients more decision-making opportunities and promote autonomy and health (Background section). In a discussion related to IUD insertion pain, OB/GYN Dr. Gene de Haan even recommends seeking someone with this type of training (Harris, 2022). While understanding and utilizing this approach may not completely resolve the ethical conflict between a provider’s obligations to minimize harm and a patient’s autonomy, I would make an educated deduction that it could mitigate some of the tension between ethical principles and perspectives.

As Pierson (2021) illustrates, this conflict between beneficence, nonmaleficence, and autonomy may also be further complicated because of unknowns surrounding possible pain and difficulties in doing something about it – a notion echoed by others who mention that it is not easy to forecast how much pain women will experience during this procedure (Davis-Hall, as

quoted in Wade, 2021; de Haan, as quoted in Harris, 2022; Gemzell-Danielsson et al., 2013). Unknowns surrounding the procedure could explain “why physicians downplay pain” (Pierson, 2021, para. 5). Each patient may have a vastly disparate pain experience (Bahamondes et al., 2014; Cauterucci, 2015; de Haan, as quoted in Harris, 2022; Goldstein, as quoted in Nudson, 2022), which means that what beneficence and nonmaleficence demand may be different across patient encounters (Bahamondes et al., 2014; Cauterucci, 2015; Gemzell-Danielsson et al., 2013; Goldstein, as quoted in Nudson, 2022; Harris, 2022; Kitchener, 2021; Pierson, 2021; Rodriguez, as quoted in Pearson, 2022). In conjunction with the forecasting difficulties cited above, Pierson’s (2021) analysis begins to address the question of whether doctors are *ethically* obligated to accurately tell patients how much pain they will experience in order to get sufficient consent if they, as the professional, do not know, in a way that prompts and informs further discussion about ethical obligations for IUD insertions. Ultimately, the very existence of this tension within the scope of IUD insertion procedures postulates this as an ethics issue (Johns Hopkins Berman Institute of Bioethics, n.d.), worthy of deliberation within the professional and academic sphere of bioethics.

Justice vs. Beneficence/Nonmaleficence

Further tension surrounding IUD insertion pain exists between ensuring access to IUDs (a justice-based obligation³) and reducing insertion pain (a beneficence- and nonmaleficence-based obligation). For example, Smothers (2018), based upon interaction with Dr. Espey, reports how women’s pain is important from the provider perspective, but IUD *access* first and foremost takes precedence (this reflects the line of thinking that promoting access fulfills the obligation to

³ See a similar extrapolation of justice in Carvalho et al. (2018) *Ethical decision making in pain management: a conceptual framework* <http://dx.doi.org/10.2147/JPR.S162926>

justice and fairness). In general, adoption of long-acting reversible contraception methods is not widespread (Shoupe, 2016, pp. 4-5). Research related to barriers to IUD access corroborates the concern: For example, Foster et al. (2015) demonstrate that “cost for women,” “knowledge of safety, acceptability of the method and expectations about use,” and “a shortage of trained providers” all act as barriers to LARC uptake, which includes IUDs (p. 546). Similarly, Yoost (2014) echoes that “patient lack of knowledge about IUDs, practitioner counseling, and cost all continue to be barriers to IUD use” (p. 953). Strasser et al. (2016) add that “requiring multiple office visits for LARC methods” also creates “a significant and unnecessary barrier” (p. 34). The tension between pain control and access is rooted in potential trade-offs that seem to occur between the two: For example, accessibility to IUDs is reinforced partly because most women can get away with not needing sedation, thus allowing the insertion to occur right in a provider’s office (Pierson, 2021). As noted, IV sedation is a possibility for IUD insertions (Pierson, 2021; Peck 2019), but it would greatly increase incurred costs on physicians and patients, the amount of time and resources for providers, and a number of unfeasible office regulations (Peck, 2019). So while IUD utilization is increasing and financial barriers are actually decreasing (Kaiser Family Foundation, 2020), we must understand and situate the current pervasiveness of structural barriers in IUD access alongside concerns around pain control to evaluate both through an ethical lens.

Yet, at the same time, additional research makes it clear that pain control itself has significant implications for access and that these factors entangled in such a way that should prompt joint consideration: It has been illustrated “that insertional pain might act as a deterrent to continued IUD use...[thus] providing a reproductive health imperative for improving the insertion experience” (Callahan et al., 2019, p. 620). A study by Akers et al. (2018) also found

that those participants who reported more pain would be less likely to “recommend[] an IUD to a friend and perceiv[e] the IUD was worth the discomfort” (p. 1130). Additionally, patients may be turned off from selecting IUC if they are afraid of insertion pain (Lopez et al., 2015, p. 2, as cited in Pierson, 2021, para. 14 & Smothers, 2018, para. 8), so therefore these studies support the notion that issues with providing pain control can directly influence access in the sense of selecting and advocating for IUD use in the first place. With this particular procedure, we must expand our view on what constitutes access beyond structural barriers to examine inattention to severe pain and inadequate pain control. The ethical tension stretches between providers’ attention to IUD access, as described in Smothers (2018), but also recognizing how pharmacological pain control could help the considerable number of patients who experience substantial pain (ACOG, 2023a; Gemzell-Danielsson et al., 2013, p. 425).

However, an interesting point raised by Dr. Espey illustrates that, beyond the potential tension between IUD access and IUD pain control, there is a systemic shortcoming within the sphere of access to actual pain control measures themselves: In certain clinics she is able to provide pain control to patients and in another she is not because of difficulty in accessing medications (i.e. clinic-specific barriers can impact ability to offer pain control) (Smothers, 2018). Therefore, a distinct ethical conflict between justice and beneficence/nonmaleficence at the provider level (operating within the confines of larger limitations) appears to unfold: There is a justice-based concern in the inability to access and provide *pain relief* (not just the IUD itself) that subsequently impacts how providers can act in beneficent and nonmaleficent ways towards their patients. Subsequent analysis must recognize that, while some tension may immediately exist between providers and patients, the real conflict is actually dictated by a larger system that may oblige doctors to provide the IUD, even while it may cause pain. With this acknowledged, it

seems that any ethical critique should be targeted towards the medical system in which providers have to make this decision: The system becomes unjust if it does not allow providers to act beneficently.

Taken collectively then, at a system level, it would be ethically problematic to try and tackle access over pain management or pain management over access at the expense of the other because they are so interconnected. Additionally, broader limitations to pain control access essentially cherry-picks components of ethical obligations to justice, beneficence, and nonmaleficence: If we want to act justly and refrain from harming *all* patients, then we should jointly consider how barriers to access constitute a justice issue and severe pain during insertion constitutes concerns related to beneficence and nonmaleficence. Without explicitly appreciating efforts for pain control, focusing on access alone by decreasing cited barriers to uptake does not necessarily mean that our handling of this procedure will be just and will eliminate all ethically-significant harms. Is it possible that by enabling more IUD access, we simultaneously expose a larger population of patients to a great deal of pain? Increasing the pool of people getting IUDs also means there are more patients having a painful experience, so access without pain control raises an additional harms-based concern. The ultimate point is this: It is equally valid to show more concern about either access to IUDs and pain control measures or experienced pain itself; what is ethically problematic is if overarching systemic justice issues require that providers and their patients prioritize one *at the expense of* the other.

The purpose of highlighting these ethical tensions is not at all to minimize the urgency of increasing access to IUDs, but rather to ask us to consider how pain control *and* IUD access can be improved at the same time. Ultimately, this disagreement between potentially focusing on access to IUDs as a manifestation of justice over beneficence/nonmaleficence to address pain

during insertion emphasizes how ethical issues surrounding this procedure extend beyond the walls of an OB/GYN clinic and prompts further conversation between providers, researchers, policy-makers, patients, and all other stakeholders.

Conclusion

Generally, we should be treating IUD insertion procedures and the potential pain surrounding them as an ethical issue and using the four principles of bioethics as a vehicle through which to do so. There is strong ethical motivation to dedicate space to more thoroughly visualizing this health care issue and explicating provider and patient perspectives to see how they may clash or pull in different directions.

The evaluation of ethical concerns related to IUD insertions generates additional research directions, reflective responses, and possibly even ethically-grounded obligations that warrant further exploration. Ultimately, because there have been significant concerns raised in the sphere of IUD pain control that are relevant to how we understand ethical duties in medicine, I would posit that there actually is a strong argument for an ethically-derived obligation to address the issue of insertion pain⁴ – an effort touched upon by Professor Rene Almeling (Tron, 2021) and Dr. Stacy De-Lin (Kitchener, 2021). Though, on to whom this obligation primarily falls may be up for debate. A follow-up response to this review may further scrutinize the potential shift in ethical obligations for pain relief during IUD insertions because the pain is actively being *caused* by the procedure and inadequacies surrounding it. An additional research direction is proposed by Dina et al. (2018) focusing on anxiety and its accompanying presumed pain because of their reported relationship between anticipated and felt insertion pain (p. 236.e8).

Overall, this analysis may be limited in scope for several reasons. It does not document

⁴ See a more nuanced discussion of a tangential type of obligation in Sullivan (2000) *Ethical principles in pain management* <https://doi.org/10.1046/j.1526-4637.2000.00031.x>

the current status of work towards developing pain control measures and their relative efficacies.⁵ Furthermore, this discussion relies heavily on anecdotal and other evidence from non-academic articles – such evidence may be biased in a way that overstates the volume of people documenting adverse and severe procedures (Cauterucci, 2015; De-Lin, as quoted in Kitchener, 2021). Still, a general observation is that popular literature provides an outlet to document the urgency related to pain control during IUD insertion and a platform for sharing patients’ lived experiences, where stories can be very informative (Sullivan, 2000, p. 276).

One study states that it is helpful to gather more data related to insertion pain (Akintomide et al., 2015), and we can follow the lead of example scientific studies, such as one by Schmidt et al. (2015), that qualitatively documents actual quotes from patients. O’Donohue (2021) points out an important gap in fully contextualizing the breadth of this pain issue:

There is no routine collection of pain scores or patient feedback when it comes to IUD procedures so how can anyone be confident that this affects a small number of women?

The data simply aren’t there to support such claims. (para. 4)

Essentially, there is a noted absence of a sort of boilerplate survey which would actually gather patient responses about possible procedure pain (Akintomide et al., 2015, p. 320). Perhaps this raises another justice concern. Perhaps it supports establishing ethical obligations. Perhaps the results of this “routine collection” could entirely shift the conversation and create additional

⁵ For further reference see Duncan (2013) *Reducing the pain of IUD insertion* <https://srh.bmj.com/content/familyplanning/39/1/63.1.full.pdf>; Gemzell-Danielsson et al. (2018) *Interventions for the prevention of pain associated with the placement of intrauterine contraceptives: An updated review* DOI: 10.1111/aogs.13662; Leon (2016) *Part 2: Minimizing the pain of the IUD insertion: all effort required* <https://thischangedmypractice.com/iud-part2/>; Samy et al. (2019) *Evaluating different pain lowering medications during intrauterine device insertion: a systematic review and network meta-analysis* <https://doi.org/10.1016/j.fertnstert.2018.11.012>; Society of Obstetricians and Gynaecologists of Canada (2022) *Statement on Intrauterine Devices, Counselling and Pain Management* https://www.sogc.org/common/Uploaded%20files/Latest%20News/Statement_on_Intrauterine_Devices-E.pdf; Whitworth et al. (2020) *Effective analgesic options for intrauterine device placement pain* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7430802/>

contradictions or solutions. But, as a woman who has delayed getting an IUD for fear of insertion pain, I sincerely hope that bringing these complicated issues and questions into the ethical space will contribute a newly-angled level of urgency in the discussion of IUD-specific pain control.

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