MEDICAL HUMANITIES REPORT

Feminist Therapies for Low-Birthweight Babies

by Hilde Lindemann Nelson
Department of Philosophy

Although the U.S. now spends close to 15 percent of its Gross Domestic Product for health care—more than any other nation in the world—the Children's Defense Fund reports that the U.S. ranks 20th in infant deaths and 31st in low birthweight rate compared with other developed countries. How can this be?

Data collected by the National Center for Health Statistics indicate that socially disadvantaged women in the United States die in childbirth at twice the rate of middle-class women and bear more than twice as many low birthweight babies, where low birthweight is an indicator that the baby suffers from serious health problems. In addition, the chances that their babies will die are twice as great. So one explanation for the low birthweight rate is poverty. According to the public health literature, the problem arises because of the way health care is financed in the United States. While even babies born below the poverty line have access to Level III neonatal intensive care centers, which can substantially reduce infant morbidity and mortality, their mothers don't always have access to good prenatal care. Since proper prenatal care has been shown to increase babies' birthweight and is considerably cheaper than the intensive care required once a low birthweight baby is born, it's commonly claimed that we have our health care spending priorities backwards. We should concentrate on providing better prenatal care for impoverished pregnant women, since better medical management of pregnancy can prevent low birthweight.

Seems obvious, doesn't it? Get rid of the problem before it starts, save lots of money that can be put to better use, go to a low tech rather than an invasive high tech treatment option-what could be economically or morally objectionable about all that? While the obvious solution to the problem of low birthweight infants is popular and pervasive, I'll argue that it's also dangerous.

STATISTICS

Low birthweight, which correlates roughly with prematurity, is defined as a weight of less than 2500 grams at birth (under 5 lbs.). Very low birthweight babies, who account for only 1.2 percent of births in the US but 46 percent of infant deaths, weigh less than 1500 grams (under 2 lbs.). The low birthweight rate has been rising over the last 20 years, both in the US and abroad. The pediatrician and ethicist John Lantos reports that in 1997 it was 7.5 percent, the highest rate since 1974 (Lantos forthcoming, p. 81). Nationally, of the 5 million babies born every year, about 53,000 weigh in at under 1500 grams. And twice as many of them are born to poor women as are born to women who don't live in poverty.

What does it cost to take care of VLBW babies? The most recent study we have is one that was published in the journal *Pediatrics* in 1998. It reports that in California, the average cost for treating VLBW babies for a year in 1987 was $93,800. By comparison, the average first-year medical costs for normal births in 1989 was $2500. If you translate the average cost for treating

VLBW babies for a year into 1996 dollars, allowing for the 62 percent inflation in health care costs, it comes to $151,956 (Rogowski 1998).

Now, if you could provide prenatal care so that the babies were born at normal birth weights rather than VLBW, how would the cost of that care compare to the $151,956 spent on average in NICUs for VLBW babies? Nobody knows, because it's extremely difficult to quantify the costs associated with prenatal care for at-risk babies. One study showed that adequate prenatal care was found to be associated with an increase of 197 grams in average birthweight—an increase too small to move even a baby who would otherwise weigh in at 1200 grams out of the VLBW range. Another study showed that prenatal interventions lowered premature birth rates among high-risk patients by 19 percent (Lantos forthcoming, p. 80). And a cost-benefit study surveying 12,023 births in Missouri's Medicaid program for 1988 indicated that for each extra dollar spent on prenatal care, there was an estimated savings of $1.49 in newborn and post-partum costs (Schramm 1992).

Other studies, however, show no results from programs to prevent premature birth. Paneth et al., for example, showed that biological factors, such as race, sex of the baby, and birthweight are all strongly associated with mortality rates, but they found no association between mortality and the number of prenatal visits (Paneth et al.1982, pp. 364-75). Moreover, despite the presence of a National Health Service in Great Britain that provides adequate prenatal care to all pregnant women, babies born into lower income families have significantly worse health outcomes than do babies born into higher income families (Racine et al.1992, pp. 40-55).

TWO WAYS OF THINKING ABOUT THE PROBLEM OF VLBW BABIES

The popular (but dangerous) solution to the problem reflects the managerial approach that pervades most of bioethics. On the managerial model, the bioethicist begins from the point of view of the health care provider or the health policy analyst, identifies a problem, and figures out an ethically sound way of managing the problem medically. The problem is that NICUs are an expensive way to address the needs of VLWB babies. The solution is to go upstream, preventing low birthweight by managing pregnant women better. This is a top-down model. To a hammer, everything looks like a nail. To a bioethics that too readily assumes a medical perspective, everything looks like a medical problem.

In contrast to the managerial model, I'd like to propose a feminist model. What makes any ethics feminist is that it pays attention to power as it circulates through our practices of morality, noting especially how gender, class, ethnicity, age, and disability mark certain classes of people for disrespectful treatment. What makes any *bioethics* feminist, then, is that it notes how imbalances of power in the sex-gender system and other social systems play themselves out in medical practice and in the theory surrounding that practice. The feminist bioethicist begins from the point of view of the relatively powerless and asks what various bodily conditions mean for them and for those with whom they are in close relationships. It's a bioethics that tries to get clear about people's needs and vulnerabilities as the people themselves understand them, and then proposes ways of responding sensitively and fairly to those needs. This is not a top-down model, but rather a collaborative one, in which the moral agency of all parties—including that of the very ill—is recognized. A feminist bioethics is suspicious of the view that everything is a nail.

How would a feminist bioethicist think about the problem of VLBW babies? The first thing he or she would notice is that the studies on the cost-effectiveness of NICUs as opposed to prenatal care focus entirely on the well-being of the babies, never the mothers. It's as if the mothers weren't there, or were important only as a kind of biological NICU that offered better health outcomes for the babies than do Level III neonatal intensive care centers. To view women

as "maternal background" is to value them only instrumentally—not as ends in themselves, but purely as means to others' ends. This, as Kant points out, is something that we may not do.

The second thing a feminist bioethicist would notice follows from the first: medical care during pregnancy isn't just supposed to produce good health outcomes for babies, but for pregnant women as well. According to a study by the Centers for Disease Control, released in June of 1999, black women are 4 times as likely to die in childbirth as whites. In New York State, 1 black woman dies for every 3484 births, while 1 white woman dies for every 13,160 births. We don't know why, because this truly immense disparity hasn't been studied (Stolberg 18 June 1999). Because there is a strong, socially shared tendency to take the adult male body, unencumbered by other individuals, as the norm for human beings, we don't really have a good understanding of the moral meaning of enmeshed bodies. As bioethics has pretty much adopted moral philosophy's individualistic conception of the moral agent, it lacks the resources for thinking well about pregnancies.

The third thing the feminist bioethicist would notice is that mothers are present in these cost-effectiveness studies only as objects to be managed and monitored. In his famous essay "Freedom and Resentment," the philosopher P. F. Strawson contrasts our ordinary attitudes of interpersonal engagement, such as "gratitude, resentment, forgiveness, love, and hurt feelings," which we display toward people whose actions reveal them to be participants in the moral community, with attitudes that preclude such engagement, because the persons' deeds show them to be morally sub- or abnormal. "To adopt the objective attitude to another human being," as Strawson memorably puts it, "is to see him, perhaps, as an object of social policy; as a subject for what, in a wide range of sense, might be called treatment; as something certainly to be taken account, perhaps precautionary account, of; to be managed or handled or cured or trained" (p. 66). The managerial approach to bioethics takes the objective attitude toward impoverished pregnant women, degrading them morally by devaluing their moral agency, seeing them as objects to be managed or handled, if not cured or trained. But to take the objective attitude toward a class of people who are fully developed moral agents is seriously wrong—it's morally disrespectful. And it oppresses women.

The fourth thing the feminist bioethicist would point out is that a policy of improving access to good prenatal care is of no use to women who don't trust the health care system. According to Lawrence J. Nelson and Mary Faith Marshall's report to the Robert Wood Johnson Foundation, more than 240 women in 35 states have been criminally prosecuted since 1985 for using illegal drugs or alcohol during pregnancy. Between 70 and 80 percent of these women are minorities. A landmark study in Pinellas County, Florida, revealed that black women were ten times more likely to be reported to criminal justice agencies for testing positive for drugs when pregnant than were white women. And a survey published in NEJM in 1987 showed that of 18 cases (out of 21 cases petitioned) in which court orders allowed coercive obstetrical interventions, all of the pregnant women were either receiving public assistance or were treated at a public hospital. Why should women who have been medically policed in these ways be eager for more policing?

FEMINIST THERAPIES FOR LOW-BIETHWEIGHT BABIES

A feminist bioethics, then, would propose three solutions to the problem. First, it would surely advocate for better access to effective prenatal care for impoverished pregnant women. This requires better studies of what works and what doesn't, including a better understanding of black women's health. But it also requires better theory. We need conceptions of the self that include physically enmeshed selves, so that we can get better moral understandings of pregnancy.

Next, rather than adopting a managerial model of prenatal care, a feminist bioethics would call for a collaborative model, one which recognizes that impoverished pregnant women are fully developed moral agents in their own right who must be accorded moral respect.

And finally, it would call for making the health care system more trustworthy. This is a particular problem for African Americans, but it's also a problem of class and gender. The solution isn't just to provide universal access to health care, though that is surely necessary, or even to provide more social services. The solution is to become a more hospitable society—one that doesn't marginalize certain classes of people or see them as fit only for others' purposes. If we as a society aren't willing to work toward that goal, we will continue to have an unacceptably high number of low birthweight babies born in grossly disproportionate numbers to women who live in poverty.

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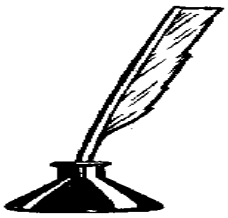
MEDICAL HUMANITIES REPORT



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Spirituality as Exclusion

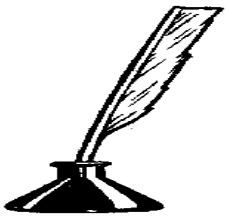
Barry DeCoster, MA
Department of Philosophy

I am trying to understand why I am hesitant about embracing spirituality in medicine. I do not see myself being very spiritual (and I admit here that I conflate being spiritual with being religious). I grew up as the only non-Catholic in my school, and being gay and remaining sane at a Catholic high school is, well, difficult. For me, spirituality still holds a lot of pain since I associate it with the Roman Catholic Church, its doctrines, and the entire system to which I didn't belong.

I'm also at the age where many of my friends are getting married, and most of these have been in religious (either Catholic or Jewish) ceremonies. I've caught myself wondering if my partner and I are missing something important by not doing something similar? There is something enticing about these expressions of spirituality: the architectural beauty of a church, the formality of the ceremony, the moral teachings of the Bible and Torah. Why wouldn't I want to take part in this?

On reflection, it's not the sense of spirituality that I am envious of, it's the sense of community. This *community* is also what I am drawn to in Clayton Thomason's suggestions to "Create a safe place," "Accept your naiveté," and "Remain flexible" (MHR, Spring 2000). These are all phrases that have been part of my political life in developing lesbian/gay/bi/trans political issues. I want to develop a community where these ideas are at the forefront. They should be universal guidelines that need not have anything to do with spiritual matters in medicine. Yet framing these concepts under a religious heading brings back all my old worries of being the only gay kid, the only non-Catholic kid in the group. Spirituality was not used to make me feel included, but instead worked to keep me feeling isolated.

MEDICAL HUMANITIES REPORT



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Spirituality as Coercion

Arnold Werner, MD
Department of Psychiatry

All this talk about spirituality in medicine is beginning to make me irritable, especially when accompanied by the usual denial of its religious intent. Oh sure, this has nothing to do with religion. Forget it. Most of the spirituality talk fosters a religious agenda, disguised though it may be. Spiritual means now, and has always meant, things religious. And in the culture we live in, the meaning of spiritual is usually Christian.

The new speak is that physicians should take care of their patients physical, emotional and spiritual needs. Ask someone what is meant by the spiritual part of the mantra and see how often the response has to do with religion. If it does not, then odds are that you will be hearing some vague talk about meeting the patient's transcendental needs, although it may be phrased in a large variety of muddled jargon.

Physicians are struggling to meet patients' physical and emotional needs, which can be rather clearly defined and we are worrying about meeting their spiritual needs? Wandering into patients' spiritual lives as part of treatment is an open invitation to the subtle, and from what numerous patients tell me, not so subtle imposition of the physician's values. After years of complaints about physicians playing God, now some of them would like to play clergy. Fine, if they want to, but it should be out of their offices and away from the bedside.

I am also irked by what I perceive to be advocating a religious view of humankind that disguises itself as embracing everyone but is really a majority viewpoint. No problem here if such talk takes place in a religious institution. In the patient-care or classroom setting the usual expression of religion is an imposition. In a secular democracy, it diminishes the validity of the beliefs—or lack of beliefs—of many members of the society and does so in a way that makes people reluctant to speak out. Why? Because they are usually in the minority and do not want to court ostracism. These are some of the problems with the expression of religion (spirituality) in public places that its advocates do not seem to fathom or to which they are insensitive.

From all of the above, the reader might assume that as a physician I do not discuss religious matters with my patients and I am unconcerned about their meaningful connections to others or their beliefs. Nothing could be further from the truth. I always ask my patients who lack social supports, struggle with isolation, and have substance abuse problems, for example, if they have or have had meaningful religious ties in their lives. I encourage these people to consider renewing such ties, if it is something they are at all inclined to do. This is not being spiritual. It is

applying sound principles of medical care and an understanding of human needs and the importance of social connectedness to good health. Oh yes, I also ask my patients about other things they have done that have lent meaning to their lives and encourage renewal of those things. I could not care less whether it is religion, running or singing that provides meaning and I doubt that it really makes any difference what it is, except to the patient.

Spirituality may be politically correct talk in some circles but it is time that people were more critical about what it means.

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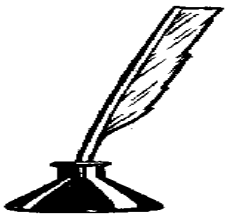

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Pain as an Enemy

Sally Walshaw, M.A., V.M.D.
University Laboratory Animal Resources

In veterinary school in the early 1970's, some of our surgery professors maintained that pain is our friend when dealing with surgical patients. The reasoning was that an animal in pain would be less likely to move about after surgery, thereby sparing damage to the surgical site or to any bandage or cast material that might be applied. Use of analgesic drugs was discouraged.

In fact, veterinary technicians providing care and observation for post-surgical animal patients have the opposite experience with analgesics in animal patients. When pain-relieving agents are given, the animal rests quietly through the first night after surgery and is likely to have a good appetite the next morning. The animal denied pain relief after surgery tends to be restless throughout the night, frequently changing positions and sometimes vocalizing. This post-operative restlessness creates the potential for adverse consequences after surgery.

A physician recently commented that treatment of pain in human beings "is not always good, especially if one does not know the cause of the pain." Physicians should err on the side of the angels with regard to pain relief. Patients can accept that diagnosis may be a difficult and lengthy process, but they definitely want relief from pain and suffering in the meantime. Pain relief will not change hematological values, serum chemistry, microbiological cultures, the results of diagnostic imaging, and the myriad of diagnostic tests available. In fact, pain has serious and detrimental physiological effects on patients. Untreated pain can interfere with anesthesia, wound healing, and bodily functions such as eating, drinking, and resting.

For the patient and the physician, pain is a billboard announcing a problem, but it is always an enemy. The physician should escort that enemy out of the patient's room as soon as possible.

MEDICAL HUMANITIES REPORT

The Center Announces New Director

The *MHR* is proud to announce that Tom Tomlinson was named as the new director of the Center for Ethics and Humanities in the Life Sciences this past July.

The purpose of the Center is to bring the insights and methods of ethics, philosophy, and other humanities and social science disciplines to the study of health care and the life sciences.

Howard Brody stepped down as Director, a post he held since 1985. After a well-deserved sabbatical this spring at the Center for Ideas and Society at the University of California-Riverside, Brody will remain active in his joint appointments with the Center and with the Department of Family Practice.

"We're very lucky to have Tom as the new Director. Besides his important administrative roles in the Center in the past, Tom has many years of service as Director of the Interdisciplinary Program in Health and Humanities in the College of Arts and Letters. Tom's role in the Center has focused on the Colleges of Arts and Letters, Osteopathic Medicine, and Nursing, and I anticipate that his assuming the Directorship will mean that we will further strengthen our ties with those Colleges. Tom also has some great ideas for new efforts and is bringing a lot of energy to the role," said Brody.

"I hope to continue the legacy of fine leadership that Dr. Brody created in his 15 years as Director, while at the same time developing new initiatives to carry out the Center's diverse mission," Tomlinson said.

MEDICAL HUMANITIES REPORT

Center News & Announcements

Judith Andre, **Leonard Fleck**, and **Tom Tomlinson** published "On Being Genetically 'Irresponsible,'" in the *Kennedy Institute of Ethics Journal*, Vol. 10 (June 2000), 129-46.

"Map-making and Myth-making in Broad Street: The London Cholera Epidemic, 1854" by **Howard Brody**, Michael Rip, **Peter Vinten-Johansen**, Nigel Paneth, and Stephen Rachman, appeared in *The Lancet* for July 1, 2000. This is the third journal article to be published by the MSU "Snowflakes." Their book, *John Snow, an Intellectual Biography*, is currently being completed and is under contract to Oxford University Press.

At the Third Annual Meeting of American Society of Bioethics and Humanities (Oct. 26-29, 2000), four of the Center's faculty, **Howard Brody**, **Clayton L. Thomason**, **Tom Tomlinson**, and **Libby Bogdan-Lovis**, served on a panel titled "Should Office Medical Records Be Altered to Exclude the Patient's Sexuality?" **Barry DeCoster** served as panel moderator.

Clayton L. Thomason presented "Telling Our Own Stories: Spiritual Autobiography and Self-Awareness," at the Michigan State Medical Society Bioethics Conference, Mackinac Island, MI Oct. 20, 2000.

Leonard Fleck presented "Gene Dreams or Gene Nightmares: Ethical and Policy Issues Related to Emerging Genetic Technologies and Embryonic Stem Cell Research," for the American Cancer Society Conference in Angola, Indiana, Nov. 9, 2000.

Libby Bogdan-Lovis and **Fred Gifford** co-presented a poster session titled "Resistance to the Results of Systematic Reviews: Management of Birth as a Case Study" at the Third Symposium on Systematic Reviews "Beyond the Basics, Improving Quality and Impact" held at St Catherine's College, Oxford, UK, this past July.

Tom Tomlinson participated in the Consensus Conference on Altered Nutritional Status (malnutrition) among nursing home patients for the American Medical Directors Association, Sept. 8-9, 2000.

Judith Andre's essay "Humility Reconsidered," was published in *Margin of Error*, Sue Rubin and Laurie Zoloth-Dorfman, University Publishing Group, 2000, pp. 59-72.