Pregnancy, pain and pathology: a reply to Smajdor and Räsänen

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ABSTRACT

In their recent paper 'Is pregnancy a disease?', Anna Smajdor and Joona Räsänen argue in the affirmative, highlighting features shared by both pregnancy and paradigmatic diseases. In particular, they point to the harmful symptoms and side effects of pregnancy, and the provision of medical treatment to both pregnant patients and those aiming to avoid pregnancy. They consider both subjectivist and objectivist approaches taken by philosophers of health in defining disease, and point out that neither approach convincingly excludes pregnancy. Finally, they present a normative case for treating pregnancy as a disease, suggesting that this attitude could promote preventive provision of contraception and abortion, and encourage respect for (and better treatment of) patients' suffering during pregnancy. In this response, I challenge various parts of Smajdor and Räsänen's argument, and cast doubt on the normative benefits of their approach.

DISEASE IS AS DISEASE DOES?

Smajdor and Räsänen argue that '[a]lthough pregnancy is not formally classified as a disease per se in modern medical practice, in many ways it is treated as such.'[1] Here, they cite both the provision of contraceptives and sterilisation by medical professionals to prevent pregnancy, and the provision of abortion as a 'cure' for established pregnancy 'preventing it from progressing to the more aggressive second stage.' However, I dispute the step these authors take from *treatment by the medical sector* to *disease*. It is true that both interventions during pregnancy/childbirth and the prevention of pregnancy lie in the remit of medical service providers—but this is not because these services are inherently medical, nor that the conditions prevented are diseases. Medical professionals have a (legally enforced) monopoly on the provision of contraceptive options and abortion. Individuals wishing to avoid pregnancy do indeed have to seek the services of their physician or pharmacist—but this is largely a matter of social contingency, rather than a reflection of medical reality.

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We may further note that there are many conditions that cause suffering, and with which medical professionals may help, but which are not pathologies. The human body simply hurts sometimes, and some remedies for this pain may be found in the pharmacy. Rachel Cooper, whose own account of disease is discussed by Smajdor and Räsänen in this article, notes the need for accounts of disease 'to distinguish diseases from conditions that are unpleasant but normal, for example, teething.'[2] Pregnancy, menstruation, menopause and breast feeding are features of female reproductive biology that can be experienced as unpleasant or painful even in the absence of pathology. To define such phenomena as diseases appears to risk sliding back in time to a view of human health based on male norms, with the female body characterised as either inherently aberrant or unusually beleaguered with ill-health.

STATISTICS, NORMALITY AND THE LIFE CYCLE

Smajdor and Räsänen briefly consider the notion of 'normal species function' (as used, for example, by Norman Daniels[3]) and argue that '[b]ased purely on numbers, pregnancy is abnormal, even within the narrowest target group we can define.' They point out that there are approximately 1.8 billion women of 'reproductive age' (defined as 15–49 years old) currently alive, and roughly 211 million pregnancies per year globally. Smajdor and Räsänen suggest on this basis that pregnancy is abnormal, asking, 'can we really insist that pregnancy constitutes 'normal species function' when most of the people in the target group are not pregnant?'

But why is normality in this case determined by distribution of pregnancy across individuals per year, rather than (for example) the statistical likelihood of pregnancy across the individual's life cycle? The problem for Smajdor and Räsänen's reasoning becomes clear when we extend it ad absurdum. Of the 211 million pregnancies per year, many will not be carried all the way to term, so for the sake of argument, let us consider only the 134 million pregnancies resulting in live birth.[4] This means that this population is pregnant for 7.4% of the year—a proportion that only increases when we introduce pregnancies not carried to full term. In contrast, the same population spends only 0.8% of the year defecating.[i] It would be obvious nonsense to argue that defecating does not constitute 'normal species function' because most people in the relevant population are not engaging in it at a given time. It seems a similarly spurious use of statistics to claim on this basis that pregnancy is abnormal. Defecation constitutes one small part of the larger process of nutrition and takes a proportionally small share of human time and energy. Pregnancy is likewise one part of the process of human reproduction, alongside birth, breast feeding and childrearing itself. Given the different scales on which some life processes take place, it does not seem logical to consider frequency an indicator of normality (or, by extension, of pathology).

CLASSES, NORMS, REFERENCES

Smajdor and Räsänen are correct to note that many philosophical accounts of health and disease fail to exclude pregnancy, but this is not necessarily a sign that pregnancy should be pathologised—in some cases, it may instead be a sign that the account in question cannot account for female reproductive processes in all their cyclical complexity, and should be sent back to the drawing board.

One account highlighted by Smajdor and Räsänen is Christopher Boorse's biostatistical theory (BST) of health and disease.[5] According to the BST, health is defined as normal species functioning, this being the statistically typical contribution to survival and reproduction of the organism's various parts and processes. These contributions are not expected to be 'statistically typical' with respect to the entire population, but rather, to a reference class. (This is what allows us to say that one person's blood pressure is healthy but another's is not, despite the read-out being identical: we say that they are healthy *for their age and sex*, and so on.) Bringing together the BST with their views of statistical normality (mentioned above), the authors state that 'being pregnant is not normal for any reference class, however, narrowly we define it.' However, Smajdor and Räsänen fail to consider the

[i] This calculation is based on a generous average of 12 min per day. Healthline suggests that a healthy stool should normally take only 1 min to pass, and that a time of more than 10–15 min is cause for medical concern.

possibility that *pregnancy itself* should be taken as a reference class.

After all, one can have a healthy or an unhealthy pregnancy. Many things on the list of 'symptoms' of pregnancy provided by Smajdor and Räsänen—such as bleeding gums, heartburn and nosebleeds—are not actually symptoms of pregnancy per se, but symptoms of pathological conditions sometimes comorbid with pregnancy. In many countries, the healthy pregnant patient would not see a physician for most of their pregnancy, but only ultrasound technicians and midwives when they come in for routine scans or prenatal counselling. Further, a routine check-up (even if provided by a medical professional) is not the same as treatment of a disease. Prenatal checks may be preventative, but they do not aim to prevent or mitigate pregnancy itself, but rather comorbidities such as pre-eclampsia (uncontroversially pathological). Taking pregnancy itself as a reference class makes sense of common practices by which we classify (a) a pregnancy as pathological or not for the age and situation of the pregnant person, and (b) specific symptoms as pathological or not for a pregnant versus a non-pregnant person.

MEDICALISATION AND MISOGYNY

Some routine appointments of the kind mentioned above have been described by critics as manifestations of overmedicalisation and surveillance of pregnant patients. These are phenomena that Smajdor and Räsänen themselves criticise; they 'emphasise the point that pregnancy is already heavily medicalised, but in ways that simultaneously tend to deprive women of patient status, thus increasing their vulnerability in the medical system.' For example, they note, women are expected to endure without complaint the kind of pain 'that would merit treatment in other medical contexts.' The authors suggest that pathologising pregnancy might reconfigure these attitudes and result in better treatment for such patients.

However, there is little reason to believe that harmful trends in obstetric care (increasingly reported and criticised in recent years[6]) would be challenged by the redefinition of pregnancy as a disease. Researchers have described the effects of pervasive misogyny across medical contexts resulting in poorer care for women despite their 'patient status'. Caroline Criado-Perez, for example, highlights female patients' greater difficulties in accessing appropriate pain medication as a result of widespread distrust of women's reliability in reporting their own symptoms.[7]

Nor are there clear grounds to think that defining pregnancy as a disease would reduce the pressures placed on pregnant patients to sacrifice their own interests for the sake of purported fetal needs. Disrespect for patient autonomy or informed consent during pregnancy and labour has been at least partly explained by appeal to the influence of normative expectations of 'maternal' behaviour as self-abnegating.[8] Some physicians and ethicists attempt to justify forced obstetric interventions or constraints on maternal autonomy by explicit reference to the parents' and physician's duties to the fetus/future child.[9] *Even if* we accept Smajdor and Räsänen's suggestion that characterising pregnancy as a disease would better enable women to access contraceptives or abortion, it is unlikely to challenge these harmful norms once a woman has decided to carry to term. The disrespect and abuse experienced by many pregnant patients is often rooted in normative beliefs about the moral relationship between mother and fetus; it is these beliefs that need challenging, rather than our definition of pregnancy.

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