

Failing to deliver: why pregnancy is not a disease

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ABSTRACT

In their article 'Is Pregnancy a Disease? A Normative Approach', Anna Smajdor and Joonas Räsänen contend that, on several of the most prominent accounts of disease, pregnancy should be considered a disease. More specifically, of the five accounts they discuss, each renders pregnancy a disease or suffers serious conceptual problems otherwise. They take issue specifically with the dysfunction account of disease and argue that it suffers several theoretical difficulties. In this response, we focus on defending the dysfunction account against their main objections and show why a version of the dysfunction account is viable on account of the indispensability of normativity in biology and medicine. After disarming their main objections to the dysfunction account, we briefly respond to their treatment of the normality of pregnancy and then draw a distinction between adverse symptoms and underlying causes to show why even though pregnancy may have 'disease-like' features, it is not a disease.

INTRODUCTION

In their article 'Is Pregnancy a Disease? A Normative Approach', Anna Smajdor and Joonas Räsänen contend that, on several of the most prominent accounts of disease, pregnancy should be considered a disease.¹ Their argumentative strategy is to present several accounts of disease and argue that for each account it either renders pregnancy a disease or it fails as a plausible account of disease altogether. They reject the account according to which a disease is a dysfunction. Drawing from Jerome Wakefield (1992), the authors claim that a dysfunction account of disease presupposes that there is a way in which the human body should function. However, they list four problems for the dysfunction account:

1. 'Function' requires a designer
2. The is/ought problem.
3. The epistemic difficulty of determining function

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4. Function is a normative concept, but life science deals only with description

They conclude that, as 'most educated people believe',¹ there is not a God who specially created us but rather we are the products of blind, random genetic mutations. Thus, there is no reason to hold that there is a way in which the human body ought to function. Further, even if there were a way in which the human body ought to function, the authors are sceptical regarding how we could ever know what such a function is. In this response, we focus on defending the dysfunction account against their main objections and show why a version of the dysfunction account is viable on account of the indispensability of normativity in biology and medicine. In other words, we apprehend and articulate functions of organs, organ systems and organisms all the time. It does not require direct appeal to a designer as is partly evidenced by the fact that Smajdor and Räsänen, themselves, unwittingly deploy the very function-talk they claim to find so implausible. After disarming their main objections to the dysfunction account, we briefly respond to their treatment of the normality of pregnancy and then draw a distinction between adverse symptoms and underlying causes to show why even though pregnancy may have 'disease-like' features, it is not a disease.

DEFENDING THE DYSFUNCTION ACCOUNT AGAINST OBJECTIONS

We have a few points of disagreement with the authors' rejection of the claim that there is a way in which parts of the human body ought to function, and consequently, with their claim that pregnancy should be conceptualised as a disease according to the best theories of disease. First, the authors freely assume the very notion of 'function' they allegedly eschew. For example, they disagree that our bodies 'should' work in any particular way but then conclude in the same sense that our bodies do, in fact 'work in a particular way'.¹ They may think this latter claim is innocuous and bereft of normative function-talk, but this is simply not the case. To say that hearts pump blood, lungs facilitate gas exchange and kidneys filter blood is to invoke function-talk. To classify some activity as

'pumping' rather than 'respiring' also assumes function-talk. On their view, the mere fact that 'our bodies work in a particular way is not an indication of how they 'should' be'.¹ However, this still concedes that there is a particular way in which our bodies work, and this concession is itself a normative claim entailing the very function-talk they try to avoid.

Smajdor and Räsänen also object that 'the concept of healthy functioning itself demands a normative evaluation. It goes beyond being merely descriptive'.¹ However, this is a feature, not a bug, for the dysfunction account, and the way the life sciences, including medicine, are practiced assumes this kind of normativity. Function-talk is, quite frankly, indispensable to the practice of life science. Prominent theorists in contemporary metaethics and philosophy of science have defended the inherent normativity of our language about organisms, and they do so without invoking theism and/or a designer.²⁻⁴ Michael Thompson, for example, argues that biology is rife with what he calls 'natural-historical judgments' about the characteristic activity of organisms. For example:

'Bobcats breed in the Spring.'

'Birds of Paradise put on dazzling mating displays.'

'Goats have four legs.'

Open any biology textbook or put on a nature documentary and you will encounter many more such examples. These capture the particular ways that organisms *do*, in fact, behave. And that implies that there is a certain way these organisms *should*, in fact, behave. Since there are right and wrong ways of labelling and evaluating organs, organ systems and organisms, this suggests a kind of normativity built-in to the way we practice the life sciences.⁴

If we grant that the human body and parts of the human body have a function (or several functions), then we must grant the claim that there is a way in which the human body, or some part of the human body, should function. And if we must grant that there is a way in which the human body, or some part of the human body, should function, then we can make use of a dysfunction theory of disease to argue that pregnancy is not a disease. For it is clear that pregnancy is at least one of the functions of the reproductive tract in the female body.

THE RELEVANT REFERENCE CLASS FOR NORMAL FUNCTION

Smajdor and Räsänen contend that pregnancy is clearly not a normal function.

However, they consider the wrong reference class when they claim that pregnancy is not a normal function. They note that there are roughly 1.8 billion women of childbearing age currently living, and that much less than half of that number are pregnant yearly.¹ However, the view that pregnancy is a normal function of the female body does not entail that the female body of childbearing age should be pregnant yearly. And so, it seems bizarre to draw from the fact that less than half of the 1.8 billion childbearing women are pregnant yearly that pregnancy is not a normal function of the female body. This simply does not follow. Thus, the annual numbers of currently living women of childbearing age who are pregnant provide data that are tangential to the question of whether pregnancy is a normal function. We cannot and should not expect to discern a normal function by considering such a narrow snapshot.

Pregnancy, as such, is a temporary event that may occur during childbearing years. As such, a given woman may never become pregnant, or become pregnant twice throughout her childbearing years, or she may even become pregnant on a yearly basis. The annual numbers of current women of childbearing age who are pregnant would not reflect the normality of pregnancy in this woman's life, or in any other woman's life for that matter. Further, the number of women who are pregnant at any given time depends partly on factors outside of biology, such as a couple's choice and socioeconomic constraints. What, then, is a better reference class for determining whether pregnancy is a normal function of a woman's body? Though a fuller response to this question is beyond the scope of this paper, suffice it to note here that a proper reference class contains data that are directly pertinent to the *function* under consideration. For pregnancy, a

proper reference class contains data from sexually active women of childbearing age throughout their childbearing years, across a wide temporal range, and from different parts of the world (to control for confounding cultural, environmental, and political factors).

DISEASE OR DISEASE-LIKE?

Lastly, we agree with Smajdor and Räsänen that pregnancy includes adverse symptoms, and can even be dangerous, for many. However, we can draw a distinction between pregnancy, as such, and the adverse symptoms of pregnancy. This distinction would not apply to measles, for instance. While adverse symptoms can sometimes be a proxy for disease, the mere presence of adverse symptoms is insufficient to demonstrate that the condition associated with those symptoms is, itself, a disease. For example, puberty is often painful and associated with adverse symptoms physically, psychologically and socially. Children undergoing puberty often experience literal 'growing pains'—back aches, headaches and obesity.⁵ Additionally, individuals may experience depression and other mental health problems during this stage of development.⁶ However, it would be a poor inference from the observation of these adverse symptoms to label puberty—a developmental stage in the life of the human organism—a disease.

This insight prevents a simplistic conception of harm from distorting our theorising about health and disease. Our approach allows us to affirm and echo their final exhortation to 'recognise and respond to [pregnancy's] disease-like features' to improve the plight of women globally without committing us to an implausible classification schema that incorrectly labels a great good of human life a 'disease' and so pathologise the

experience of women and lose important conceptual ground hard won by generations of feminist theorising about female bodies.⁷

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