CHAPTER 10

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ON WOMEN’S HEALTH CARE

In Search of Nature and Norms

Much has been said in the latter part of the twentieth century in the United States about the importance of addressing more closely women’s health and disease. Discussions have led to an increase of women physicians, women’s health care centers, and the involvement of women in clinical research projects. The call is for more attention on women’s health and disease in order to better serve women. This is to ask that we pay closer attention to how gender frames health and disease. This paper takes a look at this request. In it, I argue that gender matters in how we understand disease. The task, then, is to determine the kind, level, or degree of “gender bias” in the framing of women’s disease that is appropriate for knowledge and action. To do this, we’ll need to take nature seriously, resist empirical reductionism, and view knowledge, including moral knowledge, contextually or locally (which is not the same thing as relative). Moral casuistry, as an arm of the natural law tradition, may have some guidance to offer here in composing what I call a “gendered clinical epistemology.”

1. RISE OF THE U.S. WOMEN’S HEALTH MOVEMENT

The rise of the women’s health movement in the United States in the 1970s is a result of a complex set of influences. Issues raised by advocates of the rights of minorities, consumers, the mentally ill, and prisoners often include health care components and help reinforce public acceptance of acknowledging women’s concerns regarding their health care. The women’s health movement in particular encourages women to question established medical authority, to take responsibility for their own bodies (Boston Women’s Health Book Collective, 1973, 1998), and to express new demands for clinical research and access to appropriate health care.
Between 1974 and 1983, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) and the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) developed guidelines that require any research project that is federally funded to ensure humane treatment for human subjects (both females and males), including the acquisition of informed consent. In 1985, a Task Force on Women’s Health Issues began work to aid the Public Health Service (PHS) “to improve the health and well-being of women in the United States” (Department of Health and Human Services, 1985). In 1993, the National Institutes of Health (NIH) (1993) issued guidelines to ensure that federally funded investigations include an analysis to determine whether the interventions being studied affect women and members of minority groups differently from other groups. Further, section 429B of the NIH Revitalization Act enjoined the NIH Director to guarantee that women and members of minority groups are included in all research projects, unless exclusion is appropriate because of health, the specific focus of the research, or other circumstances that the NIH Director approves. In 1993, the Food and Drug Administration (FDA) (1993) issued guidelines concerning the participation of women in studies of medical products. Guidelines state that scientists must formulate research hypotheses so as not to exclude sex as a crucial part of the research question being asked. For example, when exploring the metabolism of a particular drug, one must routinely run tests on both males and females in order to ensure that potential differences in drug reaction and efficacy between the sexes are analyzed. In 1993 as well, the FDA altered a 16-year-old policy that had excluded most women of child-bearing potential from the early phases of clinical trials. In 1995, as reports from the Fourth World Conference on Women in Beijing and an issue of *Science* (1995) illustrate, women’s health and disease emerge as foci of concern for researchers, health care practitioners, organizations, institutions, and governments in the global order. Such attention continues into the Third Millennium with added emphasis on woman and HIV/AIDS and other immune deficiency conditions, safe motherhood practices, and maternal and child nutrition (World Health Association, 2003), and cardiovascular disease, cancer, and osteoporosis (Office of Research on Women’s Health, 2005).

Crucial to developments involving interest in women’s health is the recognition that, among females and males, many diseases have different frequencies (e.g., lupus, depression, lupus, anorexia nervosa), different symptoms (e.g., AIDS, heart disease, alcoholism, gonorrhea), and different complications (e.g., heart disease, connective tissue disease, sexually transmitted diseases). These differences can no longer be seen as inherent