will still provide a clear signal to employers.

K.C.L.

Letters to the Editor

To the editor. We reply to Jos, Marshall, and Perlmutter's article "The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale," which appears in the Summer issue.

As two people who know the health care professionals at MUSC's obstetrics clinic, we were hardly able to recognize the program described in that article.

First and foremost, we disagree with posturing the Interagency Program as something that represented a conflict between the pregnant woman and her fetus. When a woman presents to the clinic staff for prenatal care and expresses her intention to carry the baby to term, clinic personnel have *two* patients with whom they need to be concerned: the mother and the baby-to-be. The health of *both* the woman and her fetus would be improved by the woman's ceasing to take drugs. But let us be clear that the women are *not* seen as "victimizing their innocent babies, and consequently as deserving retribution." Clinic staff are well aware that these women themselves are victims.

Every effort was made to educate each woman as to the potential damage that continued drug use can have on the health of her baby; she is obviously aware of the negative effects on her own health. It was only *after* such efforts failed that legal recourse was taken to try to protect the fetus.

Yes, as the authors state, the majority of the population affected by the Interagency Policy were African American women. This is *not* due to discrimination or bias. Rather, MUSC's obstetrics clinic serves an intercity population and a population that is predominantly poor and Medicaid-eligible. Many of the clinic staff choose to work in such a setting *because* they care about the poor and their patients.

Yes, the clinic staff understands the underlying social and cultural dimensions of the problem. Yes, they wish that more support systems were available to these women, such as better residential treatment facilities and specialized services. The fact is, the clinic staff has to deal with the reality of the services that are currently available.

MUSC helped develop the Interagency Policy in part because it believes it has an obligation to *all* South Carolinians. One valid concern not mentioned in the article is the increasing and devastating economic cost for drug-addicted women to have babies. For example, in 1992, one such woman delivered two infants, in separate pregnancies, at a total cost to taxpayers in excess of $850,000 just for the births alone.

We hope that, as a result of this article and others, as well as the media attention to the controversy about the policy, that the public is informed about the specific problems. If this occurs, MUSC's actions will have some positive outcome.

Kenneth R. Whittemore, Ph.D.
Director, Div. of Health Ethics
Dept. of Health Admin. and Policy
Joseph C. Good, Jr.
General Counsel
Medical University of South Carolina
Charleston, South Carolina

Reply to Whittemore and Good. Our article was about how MUSC came to adopt and implement a punitive treatment program that provided for arrest and incarceration of those who did not complete treatment and who were unable quickly to overcome their substance addiction. This program involved a hastily developed alliance between health care and law enforcement institutions. In explaining this collaboration, we focus on the policy's development and on how it was implemented without review by MUSC's Ethics Committee or MUSC's Internal Review Board (IRB). We examine a number of explanations for the policy, and the haste of its execution, including a sense of crisis and high emotion and the nature of the target population. We also suggest that the ways clinical medicine characteristically conceptualizes problems may be more consistent with law enforcement norms than might be initially apparent. We see dangers in the origins of such policies; hence, our cautionary tale.

It is, therefore, surprising to see our work interpreted as an account of the motives and attitudes of MUSC's obstetrics clinic staff. Assessing the attitudes of the staff would make an interesting study, but that is not our study. We agree that the clinic staff must operate within the limits of available resources, that they were genuinely concerned for the health of babies born to pregnant women using drugs, and that this sense of concern and urgency helped motivate the task force to develop the policy. Our tale begins here and goes on to explore how this particular policy was developed and what some of its consequences were. Thus, the idea that pregnant women deserve retribution is, we argue, an important assumption of the policy, not an attitude we attribute to clinic staff. Similarly, the separation of the interests of the mother and of the fetus is not the attitude of the clinic staff; it is, we believe, a consequence of a policy that separated some women from their babies immediately after delivery, and returned the mothers to prison. Our discussion of the disproportionately high percentage of African Americans affected by the policy in no way attributes discriminatory attitudes to clinic staff. Again, the issue is only the effects of the policy. We did explain that a poor, African American population made the program more politically palatable, and that, independent of health and law enforcement officials' motives, the effect of the program was symbolically divisive.

Our point is that hospitals should be careful in converting good intentions into public policy. Ethics committees and IRBs exist to oversee such conversions. Had more deliberate scrutiny taken place, the result might have been an effective policy. As it stands, no evidence suggests

https://doi.org/10.1111/j.1748-720X.1995.tb01368.x Published online by Cambridge University Press