RESEARCH LETTER

Gender Bias in Critically Sick Newborns and Young Infants: An Ethical Dilemma?

Skewed sex ratios are a cause of major worry in India [1]. Genetic, environmental and social factors are responsible for this [1]. Recent surveys done in India have shown a further declining sex ratio especially in Northern states like Haryana [2]. Adverse attitudes towards females have been extensively discussed earlier in large community-based studies [3]. However, ethical dilemmas arising out of this situation especially for critically sick female infants are rarely discussed.

We share our experience of ethical dilemmas on 17 critically sick infants (12 newborns and 5 infants <4 months) admitted at a private hospital in Faridabad, Haryana (29 km south-east of New Delhi) over a period of 6 months (August 2006–January 2007). There were 11 males (two requiring more than one admission) and 6 females ($p = 0.18$). Seven required mechanical ventilation for various reasons (three prematurity, two perinatal asphyxia and seizures, one meconium aspiration syndrome with persistent pulmonary hypertension, one bronchiolitis with hypoxic seizures). There were five males and two females requiring ventilation. Four females were taken against medical advise (two of them had improved considerably) whereas only one male was removed ($p = 0.055$, Fisher exact test). Reasons given were financial restraints in all. Families spent significantly more money on males when compared to females [Median USD 522 (243.6–2292.6) vs. USD 297 (172.3–534), $p = 0.037$, paired Student’s $t$-test]. We also observed two viable sick female newborns requiring critical care being refused admission against none of the male newborns during the period. In both the out-born female newborns, parents refused admission. One was a preterm 28 weeks with HMD and other was a term baby with perinatal asphyxia with HIE Grade II. We discussed in detail about the condition of babies, chances of survival in our settings and need for intensive care. To our surprise, we received a blunt answer in Case 1 that it is futile to spend money on a female baby (parents in India especially from rural areas of North India lament the birth of females as they are worried about the future when they have to spend money on dowry for marriage of their daughters). In Case 2, financial reasons were put as a reason but attitudes and unwillingness of parents to accept a referral to a public sector hospital makes us doubt the reason.

Genuine concern towards critically sick female newborns was an exception rather than a rule. There was also a trend observed to spend significantly more money incurred on the care of the very preterm (<30 weeks) male newborns.

Many families of female newborns and infants would discuss on the chances of survival, and demand a more definite answer (yes or no) as compared to male newborns. With male newborns, they would ask us to do whatever we can to save the baby. It was especially disheartening, depressing and frustrating experience to discuss management issues in detail about the condition of babies, chances of survival in our settings and need for intensive care. We discussed on the chances of survival, and need for intensive care. To our surprise, we received a blunt answer in Case 1 that it is futile to spend money on a female baby (parents in India especially from rural areas of North India lament the birth of females as they are worried about the future when they have to spend money on dowry for marriage of their daughters). In Case 2, financial reasons were put as a reason but attitudes and unwillingness of parents to accept a referral to a public sector hospital makes us doubt the reason.

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Correspondence: E-mail <oznuryilmaz@yahoo.com>.

References


Journal of Tropical Pediatrics Vol. 54, No. 2 147
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Correspondence: Dr. Pankaj Garg.
E-mail <pankajparu8@rediffmail.com>.