

REFLECTIONS

Teaching Bioethics: Just a passing fad?

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Abstract

Biomedical ethics is not taught as a subject in undergraduate or postgraduate studies in our country. Recently governing bodies have introduced the subject in medical school in a limited manner. A majority of doctors are unable to appreciate the importance of the subject in the curriculum. This article emphasises the importance of this subject by sharing the author's personal experiences after attaining a diploma in the subject.

People often ask what impact teaching Bioethics could have on the medical profession. Most of them are sceptical about any improvement being possible. Being people of science, we medical doctors find it difficult to go beyond etiology, clinical signs and symptoms and treatment modalities. People often want to have answers in quantitative terms to the question whether teaching Bioethics to medical doctors can have any demonstrable impact or not. Finding no easy or straight answer makes them uneasy, and strengthens the notion that bioethics is just a passing fad, in vogue these days.

I got interested in Bioethics almost four years ago, and took admission in a diploma course offered by the Center of Biomedical Ethics and Culture - Sindh Institute of Urology and Transplantation, in my country. This is the only institute in a country of 200 million people that imparts any formal training in Biomedical ethics. At that time, my medical university had just one or two persons who had some basic knowledge of Biomedical ethics. I was allowed to attend the contact segment for diploma courses on the condition that I would make an attempt to introduce the subject in the curriculum of my university. As I continued my training in the subject, I began to feel the vibrations of change within myself. I started to feel a sense of deep discomfort when the information officer of a pharma company came and asked me if I would be interested in a Congress in Obstetrics and Gynaecology being held at a tourist resort. I had travelled with them in the past, so when I now refused, they were curious. The worst scenario

was when doctors from neighbouring units of the hospital posted pictures on social media, with added comments from their friends and family members, about their wonderful experiences at the conference! One day, a junior consultant came to my office and complained that the majority of consultants from other units were on holiday, except for our unit. "What is wrong with us?" she asked me, "Neither are you attending these conferences, nor are they inviting any of us nowadays". I found myself in deep water: I found it difficult to make her understand that all the money which gets spent on our fun and frolic during these conferences would be paid by our poor patients.

Since the start of my journey in the field of Bioethics, I have not availed of any of the foreign conferences funded by the pharmaceutical industry. Since I, as unit in-charge, do not encourage this practice, the junior consultants find it difficult to say "yes" to these fun tours. I did have difficulty in reducing the influence of the pharmaceutical industry within my department. They had been assisting us in getting printed stationery, all types of analgesics and antibiotics, and helping with infrastructure in the department. Getting these things done by the officials of the hospital was a challenge as well. Official administrative help is never denied in the public-sector hospitals, but obtaining it at the right moment becomes a very hard task, and we all like to have quick fixes for our problems. However, notwithstanding these challenges, I inched towards finding solutions to all these daily problems. The problem of getting stationery printed was solved when we bought a photocopier for the department. A little persistence with the hospital officials helped me improve the infrastructure of the department. Since the sample antibiotics stopped coming with this change in attitude, I started teaching my residents the importance of prophylactic antibiotics. Now we make sure that residents follow the patient safety protocol, which means patients are given baths the night before any surgical procedure; antibiotics are given only at the induction of anaesthesia, or before cord clamping. Repeat dosing is done only in special circumstances. Not only has it decreased the infection rate in the department, it has also had an influence on the expenditure on medicines.

The drugs prescribed at the time of discharge from the facility are also a source of concern. We, as doctors, are always expected to write down drugs that are popular, without giving a second thought to their cost to the patient. I remember a doctor of my neighbouring unit always prescribing drugs manufactured by her spouse's company, at the time

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of discharge. With the help of the hospital pharmacy, we customised drug packets, which included a multivitamin or iron supplement, and a simple analgesic and antibiotic if required. This also ensured that patients had medicines at the time of discharge and that made them happy as well. Now, neither am I visited by the information officers of pharmaceutical companies, nor do my staff find anyone hovering around to interact with them. This paradigm shift came after I attended the module on the physician-pharma relationship. Before attending the module, I was not aware that local regulatory authorities have issued a code of conduct on how to interact in professional matters, the responsibilities of physicians in this regard, or the concept of conflict of interest, all of which are now understandable to me.

So, when people ask me what I have learnt after enrolling in the Bioethics programme, I find it difficult to answer. There are no numbers to give them, no quantifiable measurements: changes in attitude and behaviour take a long time to get noticed. Such changes cannot be demonstrated explicitly, unless someone is observing us closely, critically, and with the will to appreciate the change.

My relationships with patients and their families have also seen a shift in approach. Like all other physicians, I had a very paternalistic attitude towards my patients. Whatever my science had taught me was good for my patient, I always practised without even taking into consideration family members and surrogate consent makers. Since the caesarean section is the most common procedure performed in the operating room, before every procedure the junior doctors were on a hunting mission for the patient's spouse to sign the consent form. Taking the consent of the woman giving birth was never even considered. She was only informed that she was being taken for the operative procedure. In the absence of a spouse, all other family members had the right to sign the document, except the woman undergoing the procedure. After being introduced to discussions on respect for the patient's autonomy, I changed this practice in my department. One of the good things for my adult learning was that I had an audience who would listen to me. It was my residents with whom I used to interact after each contact session. Now the residents know that it is the woman in the labour room who not only needs to understand the reason for her operation, but has also to sign the consent form. Though she always asks the resident to inform the spouse or any other surrogate consent giver who is with her at that time, their signatures now come under the heading of "witness." At any given time, in the training session on ethics which I conduct in my unit, there is

a minimum of 20-25 residents who are being trained. Whether this will have any impact on medical practice in the future, only time will tell.

The same module taught me about the rights of patients. As a gynaecologist I had been used to seeing patients who requested perineal tightening procedures. I had always rebuffed and dismissed them. After my own training in bioethics, my paternalistic attitude was erased and I developed the art of listening to the patient. When one such woman, the mother of five children, requested this procedure in the outpatient facility, instead of saying a firm "no," I asked her why she wanted to have the procedure. She explained that she would be thrown out of her home, if she was unable to satisfy her husband's sexual desires. This was the first time that I donned the cap of a cosmetic surgeon in order to save a marriage. It did not matter to the woman that the professional bodies of my discipline forbid such procedures, unless the mental health of a woman is endangered. Now, in retrospect, I do not know how many marriages may have been dissolved because of my earlier paternalistic attitude towards patients.

My training in biomedical ethics also introduced me to the concept of research ethics, the rights of participants, and the knowledge of infamous research trials which have been conducted in the past. After joining the institutional review board (IRB), I found physicians seeking retrospective permission for drug trials conducted earlier. And when physicians were asked to obtain approval beforehand, their standard reply was that they requested an approval letter this time, and would follow the rule in future. Once, an administrative officer who also happened to be high up in the University's hierarchy, asked the IRB for an approval letter for a clinical trial which had been completed three years earlier, in different hospitals. My research ethics module had introduced me to the concept of respect for research participants and how to safeguard research participants. It was hard to explain to the physician that the terms of reference for an IRB clearly state that permission needs to be taken *before* the start of a trial and not on its completion. This battle is still going on with full administrative support for the physician.

Coming back to the question of whether including teaching and training in bioethics in the medical curriculum makes a difference: on a personal note I feel positive that it does bring about a change in society, over time. One must realise that ethics is not an instant magic pill, but a philosophy that takes hold of you gradually and imperceptibly.