BOOK REVIEWS

Ethics in obstetrics and gynecology
Laurence B. McCullough,
Frank A. Chervenak
New York: Oxford University Press 1994
278 pages. ISBN:0195060059.

Ethical Issues at the outset of life
William B. Weil Jr, Martin Benjamin
Boston: Blackwell Scientific Publications
Boston 1987 271 pages ISBN:
0865420467

While the stated purpose of the book, Ethics in Obstetrics and Gynecology by Laurence McCullough and Frank Chervenak (an ethicist and a gynecologist) is to provide a practical approach to the application of ethics to clinical obstetrics and gynecology, most of it seems to be applicable to US clinical conditions, where court orders and legal interventions are commonplace. While the book does explain clearly the ethical duties of the doctor towards his patients (including the viable fetus), and emphasises the virtues of self-effacement, self-sacrifice, integrity and compassion on the part of the doctor; I feel that from an Indian doctor's point of view, it is too dry and theoretical. This is a shame, especially since the book is quite comprehensive in its scope, and covers a wide field of topics, ranging from contraception to assisted reproduction. however, clinical practise in India seems to be so different from the problems encountered by doctors in the West, that reading the book is quite an uphill task - and perhaps something only a book reviewer would agree to do !

While the book does have nuggets of value worth mining for - for example, the section on how to obtain informed consent from the patient is excellent; as is the chapter on the management of ethical conflicts and crises, these are hard to find. Another failing is the use of ethical jargon. While most physicians are comfortable with medical jargon, having to learn the jargon of ethicists is quite an uphill task -.and one which most doctors don't have the interest or time for - unfortunately !

Ethical Issues at the Outset of Life is an ambitious book. Not only does it discuss the ethical issues from a physician's point of view, it also tries to provide a framework (using an anthropologist's input as well !) which society can use to formulate public policy to deal with these issues. It is logically divided from a chronologic point of view, into sections dealing with in vitro fertilisation; genetics; pregnancy including abortion and fetal diagnosis; and then neonatal life.The first chapter, in particular, is a useful precis of the entire book.

I feel the major shortcoming of both these books is that though they deal with an extremely interesting and thought-provoking area, they are difficult to read and understand. While this is to bc expected, since these are complex issues, with no easy answers, that is no reason to make the task of the reader a difficult one ! The books are hardly bedtime reading, but can provide considerable food for thought to the contemplative physician, who is searching for a meaningful framework in which to practise his profession.

Sometimes, as doctors, we get so caught up in the routine of clinical practice, that we often don't stop to think about whether or not what we are doing is the right thing to do. Part of the reason is that we have not been taught to do so. The matter becomes even more complicated when we have to consider issues which were considered in the realm of science fiction until yesterday - for example, artificial twinning or cloning, techniques which can now be performed on a routine basis in the IVF laboratory today. These are thorny issues, for many reasons: they deal with the beginning of human life; technology has made dramatic adances in this field in the past few years - and societal and legal attitudes and beliefs have not been able to keep pace; and the fact that there is no rationale basis for many opinions (for example, when does life start?), as a result of which there is scope for many conflicting viewpoints.

The ultimate criterion for judging the value of a book is: doesit help me to be a better doctor ? As a result of reading these books, the thoughtful clinician will realise that there is no single right answer Alternatives do exist - especially in a democratic, pluralistic society. The best thing a doctor can do is to guide the patient to do what is best for her - promotion of patient autonomy is an important goal to strive for!

Unfortunately, most doctors are not very comfortable dealing with a patient who disagrees with them - and rather than try to resolve the ethical conflict, the patient is simply labelled as a difficult patient - and ignored.

While these books do not claim to provide easy answers, they at least offer a theoretical framework for discussion and debate.However, I think a book on ethics written for clinicians should have plenty of illustrative case histories to make it of interest to doctors. For example, a clinical case history could be presented; the ethical issues it raises and how these can then be resolved should then bc discussed. This can then lead to a theoretical framework of how ethics can be used to resolve clinical dilemmas. This would be a much more reader-friendly approach to ethics as seen from a clinican's perspective.

In most cases which raise ethical problems, the majority of Indian doctors today simply take a paternalistic attitude and tell the patient what to do. Not only is this a result of our training in large municipal and government hospitals, where patients are more often treated as cattle rather than as humans; it is also the result of the fact that in India, doctors are still treated as Gods ('the doctors knows best'); and that ethic is still not a part of the medical curriculum.

For example, as a resident,1 was ordered by my professors to insert intrauterine contraceptive devices (IUCD) in women immediately postpartum, after delivering the placenta, without even informing her - (leave alone taking informed consent!) simply because FP (Family Planning) program targets had to be met! I still cringe when I think that I did this - but I think it reflects very poorly on our entire medical system that we were willing to allow bureaucrats to tell us what to do - at the expense of the patient.

I remember how I was introduced to the novel concept (new to me at least !) of respect for patient autonomy by a visiting professor of fetal medicine from in USA . He told me of a patient he had taken care of - an unmarried pregnant 17 year old girl with a fetus which had a lethal anomaly , diagnosed on ultrasound scans, and asked me what I would do. I found the ultrasound scans very interesting - but failed to see how there were any alternative treatment options. I said that the only "logical" and therefore " right " thing to do (which I felt every sensible person would opt for) would be to terminate the pregnancy. However, the patient chose to continue with the pregnancy. She even insisted that an elective caesarean section be done, to give her baby the "best chance" even though she was counselled that in all probability the

baby would die. She did have a caesarean section - and the baby died after 4 days in the neonatal intensive care unit. At her postpartum visit, she explained that she was still happy with her decision. She felt that God was punishing her for her sins - and believed that by doing the best she could for her baby, she had "paid" for them. As a result of her decision, she was more at ease with herself and her conscience.

I'd like to conclude by describing an interesting patient I encountered recently - an unmarried woman, who requested that I do donor insemination for her. She was a young, independent woman, with a successful career, who knew her own mind, and had decided that she wanted to start a family, without being saddled by the burden of having a husband. While doing donor insemination for her as a medical procedure is straightforward, I still have doubts as to whether this is the "right" thing to do. I personally am very conservative and believe in the traditional family structure. Will her child be at a disadvantage ? Will Indian society accept her baby? On the other hand, should she be forced to marry just to have a baby ? Is a child born to a loving single mother any worse off than a child born in a family where the husband and wife are always fighting ? Using the principles of self-effacement (not allowing my own opinions to intrude); and autonomy (letting the patient decide for herself), I have agreed to do so - but am I doing the right thing ? I guess only time will tell...but at least I have a clear conscience, and have thought through the pros and cons carefully - thanks to the theoretic framework which the above bdoks provide to the physician.

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Ethical issues in the progress of medical science and technology

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Technology has made such tremendous advances over the past few years that it has been difficult for man to keep his sense of values intact in a changing society. This booklet raises some of these issues and includes euthanasia, abortion, in vitro fertilisation, organ transplantation and genetic engineering. The author, Dr A K Tharien is an ex- President of the Voluntary Health Association of India and has represented the nation at the declaration of Tokyo [on ethical issues in genetics] in 1990. Dr Tharien briefly discusses the science and the techniques of these topics before dwelling on the ethical problems. An useful appendix covers the Hippocratic oath as well as the declarations of Geneva [1948], Helsinki [196 1] and Tokyo [1990].

The pros of this book as well as its cons lie in its size - it is just 44 pages long [small size pages] and there are no references. Of these, the authors views are written in 22 and the appendices take up 15 pages. As such , it can only act as a brief introduction to the some of the fields currently of interest to medical ethicists. Serious students will have to look elsewhere for more material. For instance, the chapter on abortion is very brief and is largely on the reasons that different countries have legalised it. Although he does not specifically clarify his stand on abortion in the chapter, it clear that he is anti-abortion.

In fact, the author is obviously influenced strongly by his religious beliefs and I do always not agree with the author. He is apparently against euthanasia, something I believe in, inspite of its potential hazards. He is also not in favour of transplant operations or indeed, most of the newer techniques in medicine. I must accept that his emphasis on love as the motive and guiding principle for all health care workers and that a moral and spiritual education may help solve some of our ethical problems. He reiterates that medicine is a calling, not a profession and concludes " Only ethics based on spiritual values and love can lead our society to lasting happiness, harmony and peace." In a commentary towards the end, Frank Leavitt of Israel suggests that Dr Thariens views bc examined by bioethicists of other faiths as well as secular , strictly scientific [a politically correct term for atheists, I imagine] bioethicists.

The chapter on euthanasia is particularly well -written and has been published with some modification in this issue of Issues in Medical Ethics.

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From the World Wide Web...

On doctors' rudeness

Margaret Hughes: Everybody's dream is that a doctor talks to them and takes the time to listen to their problems and discuss the possible methods of curing the ailment. However, once the doctor really does start doing that he can never keep an accurate appointment book.

Alan Fletcher: think you are right, there are times that delay are unavoidable.

Margaret Hughes: My pet peeve about doctors is that they want to hear your complaints, but don't give you time to adequately describe them in your own terms. Due to their time constraints, they in reality stop listening as soon as they think they've got the information they need for the diagnosis.

Any listener who formulates an answer before the speaker has finished outlining the problem hasn't 'heard' all there is to consider. So, I don't stay with a GP that doesn't give me the space I need to discuss my ailments, but many do.

In searching for a good GP, I discovered that no matter how much I emphasise that I need sufficient time to express my concerns in my own way, and no matter how much the GP agrees this is a good thing and they can do that, it hasn't worked out that way. They revert to their 'assembly line? bring em in, short survey, dx(diagnosis), rx(treatment), out of the door' format, which simply does not work for me. I'm still looking for a GP that can work with me, and whom I can work with.

Jim Burns: I could not agree with you more. I have read many replies to this problem and in a study conducted on 24 family doctors It was found that, on the average, patients' visits lasted nine minutes. The doctors heard only some of the symptoms - and may have missed vital clues. Studies show that the patients who were able to fully describe their medical complaints on their first visit recovered much faster than those that didn't get the opportunity to do so.

Whats more, even doctors admit there is a problem. According to 3,352 doctors many patients feel that their doctors don't show any compassion. Worse, some doctors are seen as arrogant.

What can the patient do against intimidation?

If your doctor interupts you, simply return to the symptons. 'Be prepared with your best description of what you think the problem is, and make a list of the questions', Dr. Stewart, Professor of Family Medicine at the University of Western Ontario and an expert on family doctor-patient relations states. The key, Stewart suggests, is to be honest and actively involved. Don't be intimidated by your doctors, educate yourself. If you do not feel that your doctor is giving you the right treatment for your illness, get a second opinion.

Acquire your medical records. Do not let the doctor tell you that you cannot have them, or that he has to keep them on file for a certain period of time. This is false. In 1992 the Supreme Court of Canada ruled that the patient had the right to take his file to any other physician of his choice. To save time, arm yourself with your records and test results, x-rays and physicians' summaries of your condition.