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SOME REFLECTIONS ON ETHICS IN OBSTETRICS & GYNAECOLOGY

by

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I stand before you this morning as your duly elected President. Permit me to express my appreciation for this honour. I am conscious of the fact that before me there have been Presidents of the Federation, all of them renowned organisers, clinicians and teachers. I am a humble person associated with the Federation from its inception as Secretary to the Journal of Obstetrics and Gynaecology of India, the official journal of the Federation. My senior colleagues are known to me, as I am to them, but many of the junior colleagues know me "without knowing me", through correspondence in connection with the Journal. At our conferences, on several occasions, when I was introduced to some junior colleagues or I introduced myself to them, they have remarked in surprise "all this time we believed you are a man". I was, of course, not flattered with the remark, but also felt happy that a woman could discharge the duties as Secretary as well as a man.

When I came to know that I had been elected President of the Federation, my first reaction was, naturally, happiness at this honour. But, soon my spirits were dampened and an element of fear crept into my mind at the thought that I had to deliver the Presidential Address. I had a strong feeling to withdraw into my shell, but then my friends and well-wishers cheered me up, particularly Dr. Masani, my very dear friend of over four decades whose assistance and guidance I have always valued. Permit me to narrate a short anecdote. The Roman Emperor Nero used to throw Christians to the hungry lions. One day, Emperor Nero noticed that a certain Christian, when the lion approached to pounce upon him, whispered some words—the lion stopped, turned his back upon him and went away. The Roman guards let loose another ferocious lion upon this man. He again repeated the performance, whispered some words and the lion turn-

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ad and went away. Naturally, Emperor Nero and the whole crowd within the arena were bewildered. Emperor Nero called this Christian and informed him that he would spare his life if he told him what secret words he was saying to the lions which made them turn away. The man humbly said, "Lord Master, I have been telling them that if they eat me they would have to make an after-dinner speech".

I am convinced that each one of us, when we choose to take the medical profession as our career, we have at heart the spirit of serving humanity. However, I wish to highlight in this Address, some of the aspects where we have failed to insist that the patient and her welfare becomes the centre of our activities. We must not place patient safety and patient comfort into a secondary position. We also have to keep in mind the mental and emotional build-up of a man and a woman. The reaction of a man to an emotional insult is usually a short-lived 'blow-up', but an emotional insult to a woman is often kept 'alive' in the mental background for a long time, even for a life time. A man will shout or throw an object as his reaction and forget the incident, but a woman often is silent at the time of emotional upset, but will brood and shed tears in the quiet of her room. Therefore, we gynaecologists have an onerous duty not to treat her problems in a casual professional manner, but adopt a sympathetic approach and gain her confidence.

Every profession demands of its members ethical standards and that, in the final analysis, becomes the responsibility of every member practicing the profession. The medical profession has always been regarded as a noble profession and a'doctor' is, if I may venture to state, the friend, philosopher and guide. Advice on personal or family problems is usually sought from a medical person or a priest. All of us are aware that wherever we travel, in our country or abroad, we receive special treatment because of our profession.

Then, if we hold such a responsible status because of our profession, we must always have in the forefront, the patient's welfare and the patient's comfort. We must always remember that what we do is done by our younger generation of Residents, interns and students. I had the good fortune of having gained experience under late Dr. D. J. R. Dadabhoy and our revered Dr. J. Jhirad, the seniormost member of our Federation and Founder Editor of our Journal. Both of them maintained very high ethical standards in the profession.

Allow me to cite a few examples where we have placed patients' welfare and safety into secondary position.

Induction of Ovulation

Two drugs, HPCG and Clomiphene Citrate (Clomid) are indeed a remarkable advance in bringing about ovulation in anovulatory menstruation. These drugs are to be used only in women found suitable after full investigations. Fortunately, upto now, HPCG is not available commercially and has its proper place in research institutions. But, Clomid being easily available, is used casually in many cases without full investigations. In the absence of proper regulatory doses, not only Clomid fails to achieve pregnancy, but also produces cystic ovaries. In the bargain, the patient feels more frustrated and dejected.

Abortions

In threatened abortion, abortion in progress and habitual abortion, we pre-

scribe hormones and more recently, isoxspurine group of drugs, if I may be permitted to say so, rather indiscriminately. Progesterone deficiency as a cause of threatened abortion or habitual abortion, can be easily evaluated by excretion of pregnanediol in urine and by vaginal cytology, but, except as a research project, how often is it done in clinical practice?

The presence of 30 percent Keratinised cells in vaginal cytology indicates progesterone deficiency, but when 50 percent or more cells are keratinised, it is futile to give progesterone as abortion is inevitable. When excretion of pregnanediol is less than 5 mg. in 24 hours' collection of urine, progesterone therapy is indicated. The frequency and dosage of progesterone should be guided by repeated vaginal cytology. We delude ourselves that the hormone can do no harm, it might have some beneficial effect and more often, to protect oneself from criticism for not having administered this hormone. It is well established that in many cases, death of the embryo precedes vaginal bleeding, yet this hormone is prescribed as a routine. We have no right to believe in one way and practice in another way.

Shirodkar's operation of tightening of the internal os has brought hope and happiness to many families all over the world. A variety of methods for diagnosis of cervical incompetence have been suggested. Bergman and Sevenerund traction test in which, if a Foley catheter containing 1 ml. of water can be pulled through the non-pregnant internal os, using less than 600 gm. of pull, is suggestive of incompetence, but a positive diagnosis is best made by the finding of painless, progressive cervical dilatation with bulging membranes during the second trimester. Average success rate is 66 percent by Shirodkar procedure using Mersilene tape. We must bear in mind that incompetency of the os is one of the several causes for habitual abortion, and indiscriminate operation for tightening of the os should be avoided. Yet, it is a common experience that the operation is undertaken just because the woman had two abortions.

Dilatation and Curettage

Very few women are lucky not to have curettage at least once during their reproductive life or in the post menopausal period. The trend is well summarised in one sentence someone, sometime, some where considers curettage as necessary in a woman. I do not desire to decry this procedure in many cases as a diagnostic or of therapeutic value but I do like to emphasise that it is none too infrequent to perform curettage on infertile women having a grossly under developed uterus. The only way restrain can be inculcated is by the senior staff of teaching institution on junior Residents undergoing training.

Medical Terminations of Pregnancy

Permit me to offer a few remarks concerning the large number of terminations on married and unmarried young women —and this number is increasing.

We are all conscious of the necessity of performing these operations for checking the population explosion and preventing these women from the dangerous complications that result from attempted terminations by unscrupulous, untrained abortionists. But, are we not inviting other moral and social evils. Bhasker Rao, while delivering a Guest Lecture at a recent conference, emphasized the increase in the incidence of venereal diseases by encouraging promiscuity and

permissiveness. Are we heading for a sort of "social explosion" in future? I sincerely hope not. The most opportune time for either some form of contraception or sterilisation is at the time of termination. Motivation and acceptance is highest at this time.

Donor Artificial Insemination (A.I.D.)

There are several ethical aspects of A.I.D. which inevitably relate with medicolegal aspects. A.I.D. should never be done without the consent of the husband. It is arguable for a donor to give semen without the consent of his wife is proper and ethical. It should be clearly explained to both partners that a child born as a result of A.I.D. is illegitimate in law. The status of legitimate child is conferred on those children born during legally wedded marriage. It is unethical to carry out A.I.D. without the consent of the patient. Besides consent of the patient, the person carrying out A.I.D. must inform her that she may not become pregnant as a result of the procedure. While all doctors will probably make sure that the physical health of the donor is good and that his semen is of good quality, but it is equally important to know about his mental health and the family background, including the physical and mental health of parents and grand-parents of the donor. Besides ethics, legally a doctor could be sued by a child that is born defective, if the doctor is negligent in selection of the donor. One more ethical aspect is that the child generally will not know that he is an A.I.D. child, and it is relevant to consider whether he ought to be able to ascertain the identity of his father.

Test tube baby

First test tube baby girl Louise Brown born in England in July 1978, a real miracle, a baby of the century. Looking from ethical point of view the potential for misadventure is unlimited. What, if the baby is deformed who is responsible, the parent or the doctor? Is Government obligated to take care of it? What could prevent a scientist from taking a fertilised egg from one woman who did not want to carry her own baby and implanting in the womb of a surrogate, who then will be child's mother, which one will get the mother's card?

Induction of Labour

Induction of labour is done by some as a routine, but is it always done for the welfare of the patient? One cannot escape the belief that induction is done more for the convenience of the obstetrician and for no other reason. What is the ethical position? Does he or she become medicolegally vulnerable for performing an unnecessary medical act?

The obstetrician has to do repeated vaginal examinations so as to induce labour no sooner the cervix becomes 'ripe'. Of all the methods of oxytocin stimulation — intramuscular injections, nasal stimulation and intravenous drip— the I.V. drip is accurate in dosage, relatively safe and with the distinct advantage that it can be stopped instantly when necessary. But all this requires constant supervision by the obstetrician himself or some other well trained person. Is this routinely followed by every one? I am afraid not.

I am quite conscious that my remarks will be dubbed by many, especially the younger generation, that I am thinking and practicing obstetrics as old as my age. But one must remember that over 100 cases of rupture of the uterus following oxytocin induction have been reported in the journals, but there must be many more unreported cases.

Caesarean Section

Caesarean section for cephalo-pelvic disproportion is not infrequently performed without strict evaluation. The trial of labour that is given is more often a trial of the patience, or shall I say, impatience of the obstetrician and less of the mother and the foetus for whose benefit it is undertaken.

When consent for section is not given by the patient and the relatives, after a "trial of nerves" for a few hours, there is always available to the obstetrician the onset of imaginary foetal distress as a ready excuse to extract consent. I am aware that these remarks will not be taken kindly by many of you, but all the same they are true in practice. Dr. Krishna Menon, one of our senior respected members, made an apt, cryptic remark that the incidence of foetal distress is particularly high between the hours of 11.00 p.m. and 7.00 a.m. than at other hours of the day, resulting in high incidence of forceps deliveries and Caesarean sections. This is perhaps understandable in teaching institutions, where Residents desire to acquire technical skill. Though unethical, this may be condoned as long as the operations are performed under supervision of senior Resident staff.

As for repeat Caesarean section for cephalo-pelvic disproportion, we must remember that statistical data obtained from all parts of the world clearly show that with proper selection of cases and supervision of labour by a member of the senior staff, between 50 to 60 per cent have a successful vaginal delivery. Lower segment operation is now universal and the uterine scar withstands adequately the stress to allow a prior trial of labour. Tenderness over the suprapubic region should not be taken by itself as a reliable sign of stretching of the uterine scar, as when this criterion is taken for repeat section, usually the uterine scar is found to be intact. Although Caesarean section is in the modern era reliably safe, but it carries potential risk and a vaginal delivery should be the aim, as it not only avoids a second operation, but gives a chance for successful subsequent vaginal deliveries. As we all know, a hasty second repeat section means that third section is almost inevitably the end of the obstetric career of the patient.

In India, an accurate horoscope is valued as a predictor of important events during the life-time of the individual. Recently, I suggested an elective section on a patient whose husband, an intelligent and well-placed individual, objected on the ground that the horoscope would be inaccurate. His rather thought-provoking remark was that by doing elective operation, the horoscope would be different from the destined one, because the child would be born before the onset of natural labour. On the other hand, an auspicious day and time can be fixed for an elective section.

Surgical Operations

I feel proud to mention the surgical skills of a very high order acquired by Indian gynaecologists, but with the development of skill, there has been unnecessary proliferation of indications in some directions.

Gynaecological Operations

In at least three gynaecological operations, ethical standards are involved--ventralsuspension of uterus, vaginal hysterectomy and reconstruction of undeveloped vagina.

(i) *Ventralsuspension*

In 1915, Kelly recorded more than 50

different operations for ventralsuspension, which Kelly stated "shows the extraordinary exhibit of the fertility of the surgical imagination". At the turn of the century, few women with retroverted uterus escaped ventralsuspension. One regrets to state that in our country, ventralsuspension for infertility is taken by some as lightly as ventralsuspension in western countries at the turn of the century. The operation is readily accepted by the infertile woman and her relatives no sooner mention is made of 'upside down uterus'. This attitude on the part of gynaecologists to exploit a vulnerable situation is most unethical.

Let me recollect the lively discussion on the merits of ventralsuspension that took place at the Second Conference of Obstetrics and Gynaecology held in Bombay in 1947. One of the subjects was "infertility" and Dr. Masani, then a junior colleague, read a paper on Treatment of Infertility, in which he was very critical of the place of ventralsuspension. During the discussions that followed, late Dr. Tampan from Madras, a staunch advocate of ventralsuspension, said "I remember a number of sterile women who after having been to Rameshwaram temple to invoke the help of God to make them fertile, remained barren and conceived after ventralsuspension". In reply Dr. Masani said "I wonder if statistics are available of two groups of women—one group after their visit to Rameshwaram conceived after ventralsuspension and a second group of women who failed to conceive after ventralsuspension and went to Rameshwaram for repentence". Our revered late Dr. Shirodkar defended ventralsuspension by stating "I do ventralsuspension so that women may not 'miss the bus'". Dr. Saraiya, then a very junior colleague, made in his characteristic manner, an apt, cryptic remark "Sir, many of these women must have taken the 'wrong bus'." That was the mixed trend thirty years ago, but I believe that now the "epidemic of ventralsuspension is under control and I am sure that with present day progress in the management of infertility, this operation will be performed only when required.

(ii) *Vaginal Hysterectomy*

One feels proud to record the technical skill acquired by our gynaecologists to perform vaginal hysterectomy. Foreign statistics surprisingly record a number of urinary fistulae after vaginal hysterectomy, but in our country, the incidence of fistulae following this operation is extremely low.

But, with the ease of performance, the indications have proliferated and vaginal hysterectomy is performed in women in their early thirties for true or supposed functional uterine bleeding. Frequently, the history of excessive or frequent menstrual bleeding, as given by the patient, is taken for what it is worth and neither blood count is done to detect secondary anaemia, nor any form of hormonal treatment tried and straight-away vaginal hysterectomy is advised, which is very appealing to the patient, as it does not entail opening of the abdomen and there are no stitches at the perineum. A woman in whom red blood cell count and haemoglobin percentage does not show secondary anaemia, hormonal treatment in the form of combined oral pills for several cycles and supplementary iron therapy should be given and blood report repeated every four to six months. As long as there is no deterioration of haemoglobin percentage or RBC count, medical treatment is continued until she is forty years of age and then vaginal hysterctomy is

considered, but in a co-operative patient, medical treatment is given until menopause. Young women in whom this operation is performed, have psychological reactions which they suffer in silence.

(iii) *Operations for Reconstruction of Vagina*

Since Baldwin's operation in the beginning of the century and McIndoe's operation in the forties, we have come a long way in acquiring skill for reconstruction of the vagina. But, is technical achievement all that is required? Are there not other more important psychological problems in women with undeveloped vagina? Actually, the psychological problems commence the moment the condition is revealed to the patient. The patient is perturbed and considers herself as different from other women, which may lead to acute depression. Still more disturbing is the knowledge that, because of absent or rudimentary uterus, she will be life-long sterile. I recall two cases of women medical students who had arrangements with co-male students to get married later on. When the situation was explained, in both cases the male broke off the engagement. If that be the attitude of educated persons, one can easily guess the plight of women of the low socio-economic class. The problem of congenital absence of the vagina is only partly solved by an operation for reconstructing the vagina. One patient of mine sharply reacted "so you want to make me a perfect sex instrument". The major psychological problems seem to develop after the operation. Therefore, the problems should be discussed by the patient, the gynaecologist and psychiatrist and full implications of the aftermath of the operation should be explained to her and her reactions studied. A decision regarding operation should be made only after such preliminary preparation. Are we taking pains over these psychological problems in hospital attending patients, or are we concerned about the success in reconstructing a vaginal canal?

The medical profession requires that any information pertaining to the patient is a confidential matter between him/her and the patient. A woman consults a gynaecologist in good faith and frequently for intimate personal, physical or psychological problems and perhaps in no other branch of medicine than in gynaecology, high level of ethical standards are necessary. It should be stressed that apart from ethics, divulgence of confidential information may result in legal action against him/her.

I conclude by quoting a very wise saying "what we are is God's gift to us, what we become is our gift to God".