

Book reviews

Feminist perspectives in medical ethics

Edited by Helen Bequaert Holmes and Laura B Purdy, Bloomington, Indiana, Indiana University Press, 1992, 314 pages, £30

No longer patient: feminist ethics and health care

Susan Sherwin, Philadelphia, Temple University Press, 1992, \$39.95 hb

Laura Purdy introduces her co-edited volume on feminist medical ethics by saying: 'What I hope for in the long run is that feminism will permeate all ethics, leaving "feminist ethics" to wither away'. That must be what we all wish for, since the divergence between what these authors see as an individual-rights-based philosophy, essentially male, and a feminist-communitarian view of the world is an important one.

But in the UK we have had – still have – a welfare state. In a sense, that provides something of what the communitarian philosophy requires – care provided from cradle to grave by the state. The difficulty is, as has been made all too clear in recent years, that providing all care for all people from cradle to grave with professional staff costs more than the state, and its citizens, are willing to pay. It also has other effects we might not care for, such as a tendency to build up a dependency culture, and the removal of the wholly beneficial desire to care for our own family and friends when we can.

But the effect of care being in the community, an arguably communitarian view of the world, is that the caring falls overwhelmingly on women. Any

critique of social policy and of actual care provided makes it clear that the expectations and the reality are of people, largely women, often newly retired themselves, then spending many years caring for a family member. Care in the community of this kind is back-breaking, soul-destroying, often ill-health inducing, and has little to do with the concept of a caring community. It does, however, discriminate against women.

It is therefore essential to design a social and health-care system which has obligations and rights shared by men and women alike. In the field of medical ethics, where autonomy conflicts with social benefit as perceived by a dominant male order, that is writ large. Examples in both volumes reviewed here include the attitude to women who abuse drugs or who refuse to take medical advice during pregnancy. Drug-using pregnant women are imprisoned; women who refuse medical advice are forced to comply – in the interests of the fetus. Whose autonomy is being respected? The mother's? The potential baby's? Or are the largely male societal interests, in a society largely governed by fathers rather than mothers, being served, in forcing the individual woman to lose her autonomy in favour of a so-called greater good?

But there are other vital areas of concern. Research on human subjects comes high up the list. In Holmes's and Purdy's volume Sue Rosser argues that the assumption is made that science is objective, whilst it is clear that who does the asking, and what questions are asked, can never be objective. The whole exercise of designing a research protocol and attempting to evaluate results is done from a particular perspective, which can be thoroughly androcentric. Hence, in Britain, it is considered legitimate to exclude women of child-bearing years from most pharmaceutical trials on the

basis of possible pregnancy. The result is an androcentric approach to dosage in some drug regimens, because of lack of knowledge of the effect of doses on women's smaller frames and different distribution of body fat.

In the US, the regular complaint is not enough trials on women, with too much research conducted on conditions which affect only, or largely, men. But Sherwin, writing in Canada, feels that women need protection from too much research, and cites the use of healthy volunteer women in a cancer trial conducted by Chester Southam and his own desire not to be included, on the grounds that 'there are relatively few skilled cancer researchers and it seemed stupid to take even the little risk' (1). She also cites the notorious cervical cancer trial in New Zealand, conducted by Herbert Green and his colleagues, in which several women died and many were put to quite unnecessary distress. It is worth remembering that the New Zealand judge who undertook the inquiry into what happened was advised by a doctor, Charlotte Paul, who said of it all: 'I suggest that women were vulnerable because they were used to submitting to medical checks without being told their exact purpose. I consider that they were also vulnerable because they were exposed to examination of the genital areas by male doctors; in this situation, the asymmetry of power between the doctor and the patient is exaggerated ...' (2). Sherwin suggests that women be treated as a disadvantaged group when research on them is proposed. She also argues that it would be a major improvement if consumer organisations reflecting the interests of particular disadvantaged groups within society were consulted about research. The idea is a good one, but even better is ensuring consumer involvement on research ethics committees (IRBs) as well, and a reasonable

number of women members. As late as 1991, 28 per cent of research ethics committees in the UK (who responded to the questionnaire sent out by the King's Fund Institute) had fewer than 20 per cent female membership and only seven per cent of the committees had equal numbers of women – or a female majority (3). It is in the institutions governing research, and in the way that decisions are made, that the problems lie – and the discrimination is not conscious.

Sherwin, Holmes and Purdy have produced excellent, thought-provoking volumes. What is lacking as yet is a programme for action, but action is impossible without the analysis, which they and their colleagues have provided. We may not agree with everything. But there is enough material here for all of us to be brought up short, and think that a feminist analysis of medicine and medical training is long overdue.

References

- (1) Katz, J with the assistance of Capron A and Swift Glass E. *Experimentation with human subjects: the authority of the investigator, subject, profession and state in the human experimentation process*. New York: Russell Sage Foundation, 1972.
- (2) Paul, C. New Zealand cervical cancer trial: could it happen again? *British Medical Journal* 1988; 297: 533–539.
- (3) Neuberger J. *Ethics and health care – the role of research ethics committees in the United Kingdom*. London: King's Fund Institute, 1992.

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Choices in health care

Government Committee on Choices in Health Care, the Netherlands, Zoetermeer, Ministry of Welfare, Health and Cultural Affairs, 1992, 160 pages, free.

This Dutch report ought to be required reading for anyone who is interested in health care rationing. It was produced by a committee chaired by Professor Dunning, a cardiologist, in response to a formal request from the government, and is intended as the start of a public discussion. The

report, which is available in English, also provided the focus for a resolution of the Council of Ministers of the EEC, during the Netherlands presidency, calling for some collective co-operation within the community to enable national governments to make better choices. Quite where that European initiative will go must be uncertain until it becomes clear post-Maastricht what the content and limits of the European Union's health competence are to be.

The Dunning committee's approach is first to assert that choices are necessary, and will become more so, because scientific and technological advance will generate treatment possibilities faster than our capacity to pay for them. They suggest that there should be a basic package of care, financed collectively, which should comprise only services that meet four criteria. The committee presents these criteria as a series of sieves, each retaining some services that will therefore fail to qualify for the basic package. The four criteria are:

1. From a community viewpoint, is this service necessary in the sense, for example, that it guarantees normal function as a member of the community? Examples include continuing tender loving care for people for whom cure is out of the question, such as the elderly confused and (using Dutch terminology) people who are mentally handicapped.
2. Is this service effective, and is effectiveness confirmed and documented?
3. Is this service efficient, using cost-effectiveness and cost-utility analyses?
4. Is this something that cannot properly be left to individual responsibility?

The idea of the sieves is graphic and conceptually helpful. Personally, I find the first sieve the least clear conceptually. I can understand a sense in which immunisation is communally necessary, but not one in which (apparently) all nursing home care is equally necessary. On the other hand, I was encouraged to hear a member of the committee say that when care had to be rationed the Dutch would ration acute care but not humane care for people with chronic illness. Overall, however, the notion of communally necessary care seems much less clear in the committee's thinking than the other three criteria.

A problem that the Dutch (along with everyone else) will face is that general principles are one thing,

specific exclusions are another. In New Zealand there is a national committee at work trying to define core services. Surprise, surprise, it looks as though the core may turn out to be roughly equivalent to the range of services currently financed by the state. Similarly in the UK, once people have proposed the exclusion of tattoo removals and cosmetic surgery, the going quickly becomes rough.

One of the strengths of the Dunning report, however, is that it does take a number of examples of specific services (IVF, homoeopathic medicines, dental care for adults, sports injuries, homes for the elderly) and discusses whether they qualify for inclusion in the core. In the committee's opinion, IVF, homoeopathic medicines and adult dental care do not qualify; sports injuries and homes for the elderly do. Whether or not one is convinced, the book deserves to be widely read. It provides an alternative to Oregon in the staple rationing diet.

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Talking with patients: a basic clinical skill

Philip R Myerscough, Oxford, OUP, 1992, 200 pages, £12.95 sc.

Students often regard talking with patients as 'commonsense' and may resent teaching which they perceive as belittling. Yet there is ample evidence that the communication skills of young doctors are often seriously deficient. This discrepancy between a student's opinion of his or her skills and reality poses a major obstacle to teaching. Overcoming this requires skill and tact.

Talking with Patients falls at this obstacle for two reasons. It is very superficial, dealing with a huge range of subjects in 200 pages with only brief mention of important aspects of relating to patients such as non-verbal communication. More seriously, much of the book is devoted to the data-gathering of traditional history-taking, which is doctor and disease-oriented rather than concerned with the patient and his problem. In this the author appears as a new and sometimes reluctant convert to communication skills.