

brother and wife. He shyly told us, "I want my wife to have her pregnancy check up with you."

What exactly happened to Velu and the reasons for his almost miraculous recovery are fit subjects for a separate paper. However, the episode leads to a number of questions related to ethics and the interaction between alternative cultural / belief systems:

- At what point does non-maleficence within the framework of modern medicine need to give in to autonomy, especially when the alternatives chosen are systems of healing that we do not understand?

- At what point does our responsibility towards the patient stop - even if they refuse our form of treatment?
- What is our obligation to interact with, and create openings for, interaction with practitioners of other systems of medicine?
- How does one respond to a subsequent event of a similar nature given that the clinic and the community have had a certain experience?

We are still not sure whether we could have done things any differently, and this case remains a continuing ethical puzzle for us.

Response: caught between two world views

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As a trained allopathic practitioner myself, two decades ago I found myself in similar circumstances (1) and appreciate the dilemma of the young doctors. Since this analysis is after the event, it must be read as a tentative explanation of the confusion we often create for ourselves.

Historical influences on a doctor's professional behaviour

The beginnings of this story must go back to the time when we clinical practitioners, along with the rest of the scientific community, adopted positivism as the way that knowledge was constructed. A positivist approach emphasises "facts" as perceived by the five senses as the basis of empirical evidence. When these facts are shared by a community of "objective observers", the common ground becomes the basis of "truth" or "real" knowledge. In fact, the positivists would say this is the only truth, proven and set in stone. Interpretation does not play a role here, as the shared observation is considered to be true (1).

However, this knowledge is still from a particular point of view, however closely shared. Western science, in its claim to be objective, separated the observer from the observed and was willy-nilly given pride of place in the hierarchy of knowledge. Medicine, claiming to be a science, needed to be free of "subjective values" (1). This is one limb of a doctor's training; the attitude imbibed from it has repercussions which we shall see as we proceed.

While positivism has its strengths, it appears that its methods cannot be applied to all knowledge. In the biomedical

arena, the fact remains that, given clinical data, "normality" needs framing in the context of function and the individual. I remember the classic reflection of this in the popular "road to health" charts of the 1970s, where thousands of mothers, including myself, agonised that their babies were not achieving the desired weight for age (2). It took a while to set a norm for Indian babies, and I was left wondering if the norm for tribal babies was not different (given the specificity of the genetic pool). Second, and more important, for the doctor, "illness" is itself both a pathological and social construct. I have seen tribal women with sickle cell anaemia and a haemoglobin count of 6 grams carrying firewood home without complaints of feeling "unwell". If my observations seem anecdotal, I quote from Tauber's *Patient autonomy and the ethics of responsibility* (3:32)

Medicine both exists in, and helps create, the categories of disease and illness, which are defined and treated as part of a complex web of human values. I will flesh out this claim in detail below, but suffice it to note here that recent scholarship has emphasized how social values play into the understanding of disease, whether viewed from the perspective of psychic influences (e.g., Shorter 1988), in terms of the formulation of gender identity (e.g., Ehrenreich and English 1979; Brook 1999), as determined by cultural standards (Kleinman 1980; Good 1994), or as supported by implicit epistemological (Foucault 1973) and metaphysical assumptions (Kirmayer 1988; Fadiman 1997). Each of these

literatures highlights an anthropological and philosophical truism: disease is defined within a complex of epistemological, social, and metaphysical claims that differ between cultures (i.e., at the macrolevel), and illness manifests among a given culture's individuals (i.e., microlevel) with variables difficult to predict or quantify with any accuracy. This means that while disease has certain characteristics from the perspective of contemporary positivist data and supporting theories, other systems of understanding may determine a patient's experience of illness and even the effectiveness of therapy (Callahan 2002).

In other words, clinical medicine is scientific but uses human values as a basis for its theories and definitions of health. It is therefore a "normative" science, and there is a rich body of emerging 20th century scientific literature that explores deductive, statistical and narrative tools to understand the complex business of healing. The eminent psychologist Paul Thagard proposes a nuanced understanding of science in which many languages with their particular grammars are acknowledged as playing operative roles (4, 5). But the keyword is still "science", so the question remains: in the mind of the practitioner, whose training has stressed the scientific approach, will not positivist criteria influence his interpretation of the facts and instil the attitude of neutral and dispassionate observation?

This is the first dilemma that we have created through our definitions of "science". Do we dismiss "paranormal healing" as unscientific? Second, do we understand the difference between dispassionate observation and sensitivity to the individual patient? Unwittingly, the young doctor is trapped in this even as he is grappling with "ethics", which is - "not science."

Add to this the reductionist approach that dissects the parts or organs of the patient and makes them more important than the whole (6) and one sees the difficulties that can arise in the doctor's decision-making path. This is the second limb of a doctor's training: a need to focus on and "fix" the organ in question, rather than treat the person.

It seems that the above arguments apply to the allopathic practitioner, whose training in the footsteps of "western medicine" follows this common history. The roots of other systems of medicine, often termed "alternate" (although this depends on where you place yourself) do not share these influences; in fact we know little about how they have developed. What we tend to do is measure the interventions and outcomes with our tools, developed from a shared vision of our training, *but not that of either patient or "alternative healer"*.

An ethnographic view and hidden biases

Another vital issue is that of the cultural norm, which is distinct from ethics. The narrative describes the "marginalised community". As readers we would quickly understand and

probably identify with the 'mainstream'. Where does this vocabulary come from? Do doctors reflect on their own cultural norms with equal rigour? 'Mainstream doctors' may not have reflected on the cultural worldview they grew up with, as medical education supplanted these effortlessly, especially if there is a strong identification with the professional role. This is pertinent in the context of medical education and its hidden biases. The marginalised community may have a more holistic view of illness and disease (7) and this surely influences the choice of treatment.

And here we finally enter the world of the patient's autonomy. Well do I remember situations where the indigenous healer pulled off a "miracle" because he shared the worldview of the patient and could explain the cause of the disease in words other than "germs" or its even less clear translation in the local idiom. So let us look at the implications of a wider understanding of healing for the "ethical questions" that an allopathic practitioner must ask.

Since the primary interest is that the patient gets better, the decision finally rests with the patients themselves. There needs to be complete honesty in the weighing of alternatives to therapy and an acknowledgement of the fact that one does not know the outcomes in the other systems as well as one's own (8). In fact, this is often the beginning of learning for the truly scientific mind. Financial and personal considerations for gain are not debatable (while not a part of this story, they nevertheless play a role in many others).

Ethics is not feelings; but all stories that teach involve feelings. Both the young patient and his doctor must have swung from one end of a spectrum to the other -- fear, hope, consternation, irritation, anger, disappointment, relief and elation -- in the span of those few hours. One senses the crisis in the young doctors' minds. They are trained to prevent exactly this eventuality, yet there appears a huge barrier between them and the patient, despite the relationship with the village, trust of the patient, the reassuring presence of the referral hospital and the luxury of medical personnel accompanying the patient until treatment is started. And what of the feelings of the relatives who evidently cared enough to be there and take a stand against going to the hospital?

Somewhere missing in this melee -- or did it predominate? -- lies uncertainty. In any intervention, be it medical or "paranormal", or waiting it out, there lie the statistics of a positive outcome. And even the most scientific estimation is still a statistic. For all the predictive value contextualised to the individual patient, it remains that -- a value. Memories come of sharing information with cancer patients and being humbled to silence when asked: "And doctor, do I come within the 40% or the 60%?"

In this particular incident, religion and law do not play a role, but if they did, one can imagine how it might complicate the story.

The doctor has outlined the dilemma as: "A consenting adult

who is in dire need of specialised medical attention was being denied it by unaware but well meaning relatives."The solution:

In marginalised communities such as the Irula tribes, social cohesion is strong. Placing our faith in the benefits of this cohesion, we let the family take Velu back home to his village,

In the circumstances, the young doctors did rather well, if outcomes are to be the judge, with a fully recovered patient who brings his wife in for a check up. Evidently something in the process was right. Was it the simple act of caring with responsibility that communicated itself to the patient? By this, I mean listening, trusting and communicating with the patient and the family, taking full responsibility as the caregiver?

And if it is as simple as this, we come back full circle to medicine as a caring art, the compassion and concern for the other human being, the quality of empathy. I wonder if every couple of hundred years, we string out a spectrum, from science to art, and then bend the ends to join them. Or swing from one end of the spectrum to the other until we reset the fulcrum of the pendulum. And whether the "ought to" of ethics creates a conflict between what is and what should be. Fracturing, whether in the realms of philosophy, or clinical medicine, or ethics, only hurts the whole.

Be that as it will, the learning is both journey and destination, as the doctors discovered.

Note: I would like to acknowledge the work of Alfred I Tauber, whose writings I draw upon in this commentary.

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Technology in health care: current controversies

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