CASE STUDY RESPONSE

Learning to be humane

PADMAJA SAMANT

Department of obstetrics and gynaecology, Seth GS Medical College and KEM Hospital, Parel, Mumbai 400 012 INDIA. Address for correspondence:1101, Satsang Tower, Upper Govind Nagar, Malad (E), Mumbai 400 097 INDIA email: padmaja_mavani@yahoo.co.in

As I sit to write this numerous situations similar to the case study replay in my mind. As a resident doctor in the gynaecology department, my teachers taught me that contraception was better than interception. I thought I had to safeguard the future of women who would be facing the problems of repeated MTPs. I thought the women did not know how much trouble we gynaecologists went to do a safe abortion. The women, I thought, only knew that their "thaili" was cleaned and thought that it was as easy as washing a cloth bag, hanging it to dry and getting it refitted. I would say all this to these women in front of total strangers, unaware that I was violating their right to privacy, right to information and right to self-determination.

I was blind to the social and personal circumstances of the girls. This made me indifferent. I applied my cultural and moral norms to them and blamed the victim. I looked in horror at young girls who came for a MTP. I also cringed at the way the police and the ward attendants viewed these girls. But I could not do anything. Or maybe I thought it was not my problem. I was a mere trainee. How was I to act as a responsible citizen? Nobody told me I was wrong. Ethics is a big word but a humane approach is an easier concept to understand. But as doctors and nurses we are taught that science is devoid of the humane.

In cases of sexual assault and teenage pregnancies, casualty officers or RMOs think that when any single woman (even if she is an adult) comes for a MTP, it should be made into a police case. They do this promptly without consulting any seniors. When senior doctors make the rounds, the woman is addressed as an "unmarried primigravida". This adds insult to the injury on a daily basis. Even the front of the indoor paper bears the diagnosis "unmarried primigravida". The girl and her family go through the horror of interrogation by insensitive police, ward attendants and others.

The eligibility of young girls for an intra-uterine contraceptive devise is controversial. According to *Population Reports* (1) a woman should understand that IUD use may involve a heightened risk of infection that could lead to infertility. A young woman who has not had children may need special help thinking through a decision on IUD use. A young woman, especially if not married, is less likely than an older, married woman to have a mutually faithful sexual relationship. Thus she faces a risk of STDs and of subsequent infertility that might be increased by IUD use.

But government dictates speak of achieving targets or promoting use of contraceptives. Doctors have learnt to think that illiterate and poor women do not follow the instructions for oral pills and their partners are not willing to use condoms. So the IUD is regarded as the best one time, ten-year guarantee that the patient is protected from the risks of MTPs.

Another tragedy of our public health facilities is that the doctors, nurses, and paramedical staff do not work as a unit. The nurses are in a position to be of immense support and help to women in distress. But they are excluded from training in gender, law and medicine. The doctors' familiarity with laws is commonly restricted to malpractice issues and there is a great confusion about legal procedures and medical practice. Doctors, lawyers, and the police really need to come together in a sustained forum on the health implications of atrocities against women.

Reference

1. Treiman K, Liskin L, Kols A, Rinehart W. IUDs - an update. *Population reports* Series B. No 6, Baltimore: Johns Hopkins School of Public Health, Population Information Program; December 1995.