tional labors in the epidural group. Not noted was the duration of stage 1 or whether oxytocin was begun before or after the epidural was in place.

The authors also fail to separate out one subgroup that may not be at increased risk. Presumably, one reason for instrumental delivery is abolition of the mother's "urge to push" by epidural anesthesia. In our experience, women who have undergone a previous spontaneous vaginal delivery (without epidural anesthesia) are able to push adequately if they are given proper cues to timing of efforts.

It may be tempting to extrapolate the findings reported in this study and conclude that epidural anesthesia causes instrumental delivery and therefore should be avoided. We believe that caution should be exercised before drawing such a conclusion for all women who may request epidural anesthesia. In his comment, Dr. Duhring asserts that, "women well trained in LeBoyer or Lamaze childbirth do not find the pain of labor overwhelming."

Circumstances such as prolonged labor or Pitocin™ induction/augmentation can indeed overwhelm the psychic resources of even the most well-trained patient. To deny these women, especially those who have undergone a previous spontaneous delivery, the benefits of epidural anesthesia would be a grievous error.

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References

1. Niehaus LS, Chaska BW, Nesse RE. The effects of epidural anesthesia on type of delivery. J Am Bd Fam Pract 1988; 1:238-44.
2. Smith MA, Brix KA, Heaton CJ. The influence of work on the outcome of low-risk pregnancies. J Am Bd Fam Pract 1988; 1:167-74.

The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: On behalf of all the authors, I would like to thank Doctors Mengel, Daugherty, and Horner for their interest in our article and thoughtful comments.

Doctor Mengel's letter summarizes a definition of bias very nicely and specifically suggests that surveillance bias is present in our study. Of course, the presence of surveillance bias is a basic truth in any retrospective study and is readily acknowledged by our group. Doctor Mengel's letter goes on to suggest that a prospective study done in a blinded fashion is needed. While this has great merit, there are some practical limits. It is difficult to conceive how one could truly construct a double-blind study, given the equipment used for continuous epidural blocks. In addition, the vast majority of physicians believe that knowledge of the patient's anesthesia status is essential for proper medical care delivery. Doctor Mengel's letter concludes that control of multiple confounders at the same time was needed. Indeed, the study did simultaneously control for all of the 10 variables listed and found that the effect of epidural anesthesia on the outcome of labor and delivery remained significant.

Doctors Daugherty and Horner's letter addresses the differences found in the patient cohort receiving epidural block versus the cohort that did not. It is important to note that subgroups were compared that were matched for risk. It is our belief that statistical methods were adequate to control for the differences and allowed us to select comparable subgroups from the total population. Daugherty and Horner's letter also points out other population factors not directly studied that may have a significant effect on labor outcome. One could not debate that the use of Pitocin™ to augment labor is necessary due to the effect of epidural block. However, we acknowledge that there may be many modifiers beyond the 10 we listed in our article that adversely effect delivery type. We strongly agree with Doctors Daugherty and Horner that, while it may be tempting, one should not extrapolate the findings of our study and conclude that epidural anesthesia is the "cause" of instrumental delivery. However, as we stated in our article, " . . . epidural anesthesia during labor is associated with increased instrumental and operative deliveries . . . ."(p 242)

Would selective application of epidural blocks in a yet-to-be-defined optimal subgroup of patients completely eliminate the adverse effect of the procedure? Can the present adverse effect of epidural anesthesia be completely eliminated by different labor management techniques? The answers to these important questions will need to be supplied to physicians by further studies of low-risk obstetric patients.

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Medical Ethics

To the Editor: I was dismayed by many aspects of Dr. Pellegrino's article entitled "Medical Ethics: Entering the Post-Hippocratic Era" (October–December 1988) and would like to address what I believe are significant shortcomings in his paper and possible sources of misunderstanding.

In his "Deconstruction of the Hippocratic Precepts," Dr. Pellegrino sees in the preamble of the *Oath* a "sexist, elitist, monopolistic, and wholly inappropriate" concept of medicine. I would point out that, from an educational and socioeconomic standpoint, entrance into medical school is now as about as elitist as one could ever imagine. Giving this instruction to "my sons and those of my teacher" can be understood as the modern physician's obligation to teach medical students and residents. Furthermore, the injunction to reserve this teaching to those properly sworn and engaged can be

correlated to our current-day state licensing boards and medical specialty colleges.

"The most serious and problematic challenge" is seen by Dr. Pellegrino in the first precept, "I will use treatment to help the sick, according to my ability and judgment . . . ." This supposedly represents the origins of medical paternalism and authoritarianism. I would propose that physicians have no other means to help a patient but their abilities and judgments and that an authoritarian attitude in modern physicians is not so much an atavism of Hippocrates as it is a prideful misuse of the power entrusted to them and a misunderstanding of their own limitations.

Further, the admonition for the physician to pursue his life and art in purity and "holiness" (also translated as "innocence") is described as not realistically applicable due to the "impracticality of regulating private morals." Concerning euthanasia, the text of the article implies that if enough voters in California say so, then the medical profession should reject the Hippocratic injunction against this. Likewise, a Supreme Court decision on abortion relieves the physician of any personal, moral questioning in this regard.

The author also seems willing to discard the injunction against a physician using the intimacy of the doctor-patient relationship to satisfy his sexual desires, based on the suggestions by "a small number of psychiatrists . . . that having sexual relations with their patients is morally permissible or even therapeutic."

Finally, the precept of confidentiality, because it cannot be adhered to in an "absolute" manner, invalidates its usefulness in the field of modern medicine.

Each of these criticisms of the *Oath* indicates a superficial, legalistic approach, attempting to establish a verifiable code according to the letter of the law, which could theoretically be embraced by all physicians. This disregard for the spirit of the precepts of the *Oath* does not forebode well any attempts to restructure it.

Dr. Pellegrino states that, "Medical ethics as a formal discipline began seriously only two decades ago when the moral assertions that had sufficed for so many centuries became problematic." This appearance as a separate discipline could also be attributed to the gradual disenfranchisement of ethics from the core of medicine as we became more materialistic as a society and as a profession.

While one cannot deny the obvious effects that technological advances have had on the field of medicine in the past 15 years, I would dare to warn anyone who states that the conditions in which we now live are unique and exceptional that this outer change is all the more reason for one to turn to the moral foundations of ourselves and our profession. Perhaps what is needed is not a new set of precepts, but a way of looking at these precepts in a new light in order to better understand them and the discipline that they were intended to guide.

It is reassuring that Dr. Pellegrino's stated purpose, "is not to deprecate that noble edifice." I believe, however, that rather than dismantling the *Oath* in order to write a platform statement to be accepted by all factions of a medical party, it should remain as the monument it is under the eaves of which we may examine our consciences and struggle, individually first, and then collectively, to reincorporate the moral into the medical profession.

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To the Editor: I have some observations to make on Dr. Pellegrino's guest essay on "Medical Ethics" (October–December 1988).

It seems that the basis of his essay on "Medical Ethics" and the Hippocratic *Oath* is "situation ethics" and moral relativism. It might stem from trying to compare a scientific discipline that is constantly changing with that of ethical and moral philosophy that is really unchangeable or immutable. The Hippocratic *Oath* has stood the test of 2000 years and probably can't really be improved upon. It is really based quite well on the natural law and the Ten Commandments, and if one believes in God and believes that He does not change His mind in regard to moral precepts, then we as physicians had better think seriously about our responsibilities to the Almighty and not try to change His precepts to our human ways of thinking.

Dr. Pellegrino attacks one of the first principles of the *Oath*, that of the brotherhood of physicians, which he says is no longer "appropriate in democratic societies." I disagree. I think that the fraternal concept has served patients and physicians well and has increased the quality of medical care. Physicians have traditionally cared for one another gratis, and this example has been followed by giving free care to the poor. The fraternal concept has enhanced the concept of a profession dedicated to high standards, and the physician has been looked upon as being altruistic and not merely interested in money. The American Academy of Family Physicians and the American Board of Family Practice are products of this fraternal spirit.

I do agree with Dr. Pellegrino that we are in a post-Hippocratic era; however, this is not due to medical advances or changes but is the result of decadence in our society, which has affected our profession. According to Robert Louis Stevenson, doctors as a group seem to avoid the horrendous errors of our times. We, therefore, do not need to jettison or change the principles in the *Oath*. We need to rededicate ourselves so we can again practice medicine with "purity and holiness."

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Intrathecal Morphine in OB

To the Editor: Safety and utility of intrathecal morphine for labor pain has been reported by Edwards, et al.[1] To mitigate side effects, the authors recommend naloxone 0.8 mg in each 1000 mL intravenous fluids supple-