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.

Philip Heinegg, M.D.
Larchmont, NY

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."

George W. Merkle, M.D.
Carlsbad, CA

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-

J Am Board Fam Pract: first published as 10.3122/jabfm.2.2.138a on 1 April 1989. Downloaded from http://www.jabfm.org/ on 8 September 2024 by guest. Protected by copyright.

mented with 0.1 mg bolus. The rate recommended (100 mL/hour) appears to be safe, but it is possible that the patient may require or unintentionally receive fluids at a faster rate during labor, delivery, or postpartum. Naloxone, even in small doses (100 μg), has been shown to be hazardous following systemic opioid administration.[2] In addition, naloxone may reverse analgesia,[3] or breakthrough pain may occur. Potential problems regarding naloxone administration may be lessened by "piggy-back" infusion using a well-marked burette administration set with, for example, naloxone 80 μg in 100 mL intravenous fluids. Possibly, an even safer approach is administration of a narcotic agonist/antagonist such as butorphanol tartrate or nalbuphine hydrochloride. Nalbuphine has been shown to decrease clinically significant respiratory depression[4] while providing some analgesia of its own.[5] Davies and From[6] reported that nalbuphine 10 mg subcutaneously resulted in significantly less pruritus following epidural fentanyl. The possibility of respiratory depression in the neonate—especially in premature infants—following systemic administration of any opiate to the parturient should be considered.

Robert P. From, D.O.
University of Iowa
Iowa City, IA

References

1. Edwards RD, Hansel NK, Pruessner HT, Barton B. Intrathecal morphine as analgesia for labor pain. J Am Bd Fam Pract 1988; 1:245-50.
2. Prough DS, Roy R, Bumgarner J, Shannon G. Acute pulmonary edema in healthy teenagers following conservative doses of intravenous naloxone. Anesthesiology 1984; 60:485-6.
3. Rawal N, Schott U, Dahlstrom B, et al. Influence of naloxone infusion on analgesia and respiratory depression following epidural morphine. Anesthesiology 1986; 64:194-201.
4. Doran R, Baxter AD, Samson B, Penning J, Dude LM. Prevention of respiratory depression from epidural morphine in post-thoracotomy patients with nalbuphine hydrochloride. Anesthesiology 1987; 67:A248.
5. Henderson SK, Cohen H. Nalbuphine augmentation of analgesia and reversal of side effects following epidural hydromorphone. Anesthesiology 1986; 65:216-8.
6. Davies GD, From R. A blinded study using nalbuphine for prevention of pruritus induced by epidural fentanyl. Anesthesiology 1988; 69:763-5.

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

To the Editor: Dr. From has submitted some productive comments on the use of naloxone to control the side effects of intrathecal morphine for labor pain. I agree that it is possible for patients to receive unintentionally intravenous fluids at rates greater than 100 mL/hr, which could be unsafe; however, I continue to recommend supplementation of naloxone in 0.1 mg intravenous bolus as needed rather than an increase in the intravenous rate greater than 100–125 mL/hr. Dr. From has pointed out the possible side effect of pulmonary edema from naloxone administration. I agree we should be aware of this side effect, but in the references cited, the patients who developed this either had preexisting cardiac disease[2] or had received multiple other medications during anesthesia.[3] While it would seem that use of naloxone would oppose the analgesic effect of the intrathecal morphine, this has not been my experience, nor was it reported by Poul and colleagues.[4]

Nalbuphine or butorphanol may be safe alternatives to naloxone[5] as suggested by Dr. From, provided that adequate attention is given to their respiratory effect on the newborn who has no narcotic on board for these to act as antagonist.

My conclusion, after reviewing the literature, is that nalbuphine and butorphanol may be useful alternatives in some patients, but at present, in the healthy pregnant patient, naloxone is the safest choice to control the side effects of intrathecal morphine.

Rick Edwards, M.D.
Grand Prairie, TX

References

1. Edwards RD, Hansel NK, Pruesser HT, Barton B. Intrathecal morphine as analgesia for labor pain. J Am Bd Fam Pract 1988; 1:245-50.
2. Flacke JW, Flacke WE, Williams GD. Acute pulmonary edema following naloxone reversal of high-dose morphine anesthesia. Anesthesiology 1977; 47:376-8.
3. Prough DS, Roy R, Bumgarner J, Shannon G. Acute pulmonary edema in healthy teenagers following conservative doses of intravenous naloxone. Anesthesiology 1984; 60:485-6.
4. Poul H, Soren SS, Jphannes EB, Alvito F, Anni S. Intrathecal administration of morphine for the relief of pain in labor and estimation of maternal and fetal plasma concentration of morphine. European Journal Obstetrics Gynecology Reproductive Biology 1987; 25:195-201.
5. Henderson SK, Cohen H. Nalbuphine augmentation of analgesia and reversal of side effects following epidural hydromorphone. Anesthesiology 1986; 65:216-8.

Rural Obstetric Care

To the Editor: If the scientific method may be defined as the careful testing of a hypothesis, then Dr. Wain Allen's article "Obstetric Care in a Rural Family Practice" (January–March 1989) qualifies in spades. The hypothesis seems to me to be that a competent, dedicated, well-trained family physician can safely "deliver" obstetrical care in a rural environment. The numbers, though small, are carefully assessed and reported. The writing is succinct, and the distinction is made between opinion and fact. I disagree with Dr. Paul Young's editorial comment that the "data do not scientifically establish any specific hypothesis" or that "fetal outcomes are not documented." There were no deaths, and the one premature birth was "normal at 2 years of age." Perhaps I do not understand what more Dr. Young requires.

My congratulations to the editors for publishing this much needed article from the trenches of family medicine. It should encourage the submission of similar private practice studies to family practice journals.