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Informed consent and cultural sensitivity

To the editor – The case study by Tshifularo *et al.*¹ raises at least three issues.

1. Informed consent. As we read it, the patient seems to have been hesitant to have only the medically indicated tonsillectomy performed because of his cultural belief. Therefore, the patient '*reluctantly* gave his informed consent' to the tonsillectomy. Either the choice of words was unfortunate or the informed consent was in fact no consent at all. To be valid, informed consent must always be voluntary; i.e. agreement to [a procedure / treatment etc.]. Any act, which is not voluntary, is unethical. It is impossible to '*reluctantly*' consent. The patient wanted a specific procedure that was deemed not indicated for his condition by the attending physician. For this reason, he '*reluctantly*' gave informed consent to a procedure he did not want. It would have been proper to refer (provided there may be some indication for an uvulectomy in other circumstances) or to decline the surgical procedure altogether. The patient used (presumably) his autonomy by attending a traditional healer to solve his problem. The complications of the traditional surgery are not the Western medical practitioners fault. He (presumably) made the autonomous choice of giving fully autonomous informed consent to the procedures necessary to contain his haemorrhage.

2. Performing a procedure solely on patient's request. Ethics come into play when considering the issue of distributive justice and scarce resources. In the case study, it is unclear to the reader whether there is any benefit derived from a non-medically indicated uvulectomy; but there is clearly a risk. The question is, should one perform procedures simply on patient's request.

3. Cultural sensitivity versus cultural relativism: The doctor-patient relationship. The paper argues that the doctor-patient relationship was adversely affected by the team's lack of cultural sensitivity. We would argue

that the relationship was more affected by obtaining a "reluctant" consent, and that cultural sensitivity does not mean moral / cultural relativism – i.e. something is right because it has cultural approval. If one agrees with moral/cultural relativism there would be nothing wrong with female genital mutilation and slavery.

It seems that 1) the physicians involved feel (justifiably) sorry for what happened to the patient and 2) that if they had been more culturally sensitive the resultant medical misfortune could have been avoided. The latter is problematic because it is unclear as to just what they are trying to say. Reading it in the extreme, viz. submitting to the patient's request for a non-medically indicated procedure presents grave ethical problems. Just because my culture believes that it is acceptable to remove my healthy uvula does not make it morally right or acceptable. What is morally wrong is universally wrong, regardless of specific cultural beliefs. For Kopelman, judgements do not describe what *is* approved but describe what *ought* to be approved. Claims about alleged benefits of traditional procedures should be open to cross-cultural examinations to determine the possible costs and benefits. Highlighting our differences should not eclipse the fact that we share many goals and values and that we are similar enough that we can assess each other's views as rational beings in a way that has moral force. A cultural value has no moral authority. We should be culturally sensitive but we have the right to evaluate morally cultural practices inside and outside our own cultures.²

All human beings share common needs, goals, and methods of reasoning and evaluation that enable us to evaluate claims across cultures. Certain moral claims can be challenged, even when we have different cultural values. A cultural point of view has no moral authority even if it plays a role in shaping our moral judgments.² As pointed out by Gyekye, no human culture is absolutely reluctant to change and exchange and traditions may be revisited on normative grounds.³

Informed consent viewed as a process (a continuous dialogue involving e.g. respect, shared information, enquiries, and thoughts) may represent a powerful vehicle for sharing cultural information. Cultural sensitivity might find its way into a doctor-patient relationship during the on-going process of obtaining a fully informed autonomous consent. The concepts of cultural sensitivity and cultural / moral relativism should be clearly identified.

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Increased cardiothoracic ratios and hypertension among steel mill workers

To the editor: The prevalence of hypertension and increased cardiothoracic ratios was studied in 714 steel mill workers. Hypertension was very prevalent and occurred in 36% of the population. Increased cardiothoracic ratios (defined as increased if more than 0.45) occurred in 42% of the population.

A study was performed to measure whether any relationship exists between hypertension and noise-induced hearing loss. In order to lower the inherent bias of the researcher searching for a relationship between two variables, a third variable was also measured, namely CTR or cardiothoracic ratio.

In an article by Hemphill and Eisenberg, the cardiothoracic ratio is defined as the maximum diameter of the cardiac silhouette divided by the maximum internal thoracic diameter at full inspiration, which is usually 0.45 or less in adults.¹ This ratio should be calculated on a good quality posterior-anterior chest x-ray taken at full inspiration, which means the base of the lungs should be visible or that the chest cavity should extend lower than the tenth ribs.

The steel mill has an annual hearing screening programme and routine chest X-ray for high-risk employees as part of its occupational health programme. A group of 714 employee records were selected from an occupational health database. Approximately 1 700 records were available, of which only 714 were included for analysis (see Table I for the characteristics of the sample). Hypertension status, audiometric screening results and chest X-rays were retrieved. The data from the occupational health records, clinical notes and occupational health X-rays were entered onto a questionnaire. The occupational health data on the data retrieval questionnaires and audiograms were checked a second time so as to correct any mistakes before analysis commenced.

Table I: Characteristics of the sample

Variable	
Age (mean)	44 (SD 7) years
Age (range)	27 to 61 years
Duration of exposure (mean)	22 (SD 6) years
Duration of exposure (range)	10 to 39 years
Gender	Males only
Race	296 Caucasian
	418 Black
TOTAL in study population	714

The criteria for being included in the study are as follows:

1. The employee had been working at the steel mill for ten years or more.
2. The employee had an occupational health record containing the following information: demographic data such as age, as well as data on where the employee had worked in the mill and years of exposure, two audiograms done in the past two years (1996 and 1997), a posterior-anterior chest X-ray done in the past two years (1996 or 1997) and two blood pressure readings taken in the past two years (1996 and 1997).

3. The employee had been exposed to the steel mill environment and the high-risk noisy areas.

The criteria for exclusion are as follows:

1. Occupational health records had insufficient clinical data, as defined under inclusion criteria, such as audiological data, chest X-rays or clinical notes.
2. The employee had not been exposed to noise, for example purely administrative or security personnel.

Table II: Reasons for Inclusion and Exclusion

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Total number of records in the database	1702
Number of records excluded for the following two reasons:	757
1. Insufficient clinical information, audiograms, clinical notes and X-rays	
2. Lack of exposure to noise, for example office employees and security employees	
Number of records excluded because of insufficient length of exposure time (< 10 years)	231
Total number of records analysed	714

The prevalence of hypertension in the workplace depends on the classification used. Thirty-six percent of the study population had diastolic pressures of 90 mm Hg or more. If the epidemiological definition of hypertension is taken as a systolic blood pressure of more than or equal to 160 mm Hg and/or a diastolic pressure of more than 100 mm Hg, the prevalence of severe hypertension was 12%.

No relationship between hypertension and noise-induced hearing loss could be proven, irrespective of the different epidemiological definitions of hypertension and the different epidemiological definitions of noise-induced hearing loss used (OR = 0.55 Exact 95% CL 0.19 < OR < 1.31, p = 0.1102).

However, a weak relationship was found between hypertension and increased CTR (cardiothoracic ratio) (OR = 1.8 Exact 95% CL 1.08 < OR < 2.99, p = 0.016). No relationship between increased CTR and race or age variables could be proven.

The study indicates that noise-induced hearing loss, hypertension and increased cardiothoracic ratio (increased if more than 0.45) are prevalent conditions and should be screened for, prevented and effectively treated so as to minimise their complications. The study also indicates that uncontrolled hypertension is positively but weakly associated with increased cardiothoracic ratios.

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Reference

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