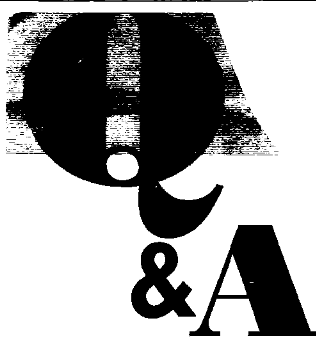

&A

with

Dr. John D. Stephens

Few people have prompted the kind of heated debate that has surrounded Dr. John Stephens in recent years. We spoke to Dr. Stephens, who runs the controversial Koala Labs ultrasound clinic in Blaine, Washington, about his reputation within the Indo-Canadian community and the controversy surrounding the services he provides.

Mehfil: Describe your services.

Stephens: "The services in the office out of Blaine are for couples who want to find out two basic things — is the baby healthy, and is it a boy or a girl. And I am able to offer this at a very early stage in pregnancy, essentially with the opportunity to reliably tell whether it is a boy or a girl starting at the 12th week. The accuracy of the gender or sex determination is equal to the accuracy of them having genetic tests like an amniocentesis, tests which have risks associated with them such as a chance for miscarriage. The ultrasound offers not only safety, but it can be combined with looking at other parts of the unborn baby to answer questions about health.

Mehfil: So your services don't simply track pregnancy disorders, because if they did people from the Lower Mainland wouldn't need to jump the border for these services.

Stephens: "There are many times a woman may want to or may even need to have a sonogram, but is unable to access this through the Canadian medical system. Sometimes they should get it but don't get it, and that's because of a lack of sophistication of the physician in some cases. In other cases, it may be due to the physician saying, 'I don't think you need it." But the patient doesn't have a say. Once the patient has an alternative, then the patient doesn't even go to the physician. In the States, we have a different historical perspective in terms of patients accessing medical information."

Mehfil: Do you worry that people use your services for the wrong reasons?

Stephens: "Well, right there, you've introduced a qualitative aspect to the question. If my services are recognized as being medical, legal, and accurate, and patients have the right to freedom of choice, is there any role for a physician to determine whether it is or isn't appropriate? It is medically inappropriate for a physician to interfere with the patient's access to medical services. It is also unethical for a physician to interfere, and it's even unethical for a physician to not help a patient when they ask for a particular medical service and the physician knows where that patient can get that service or information about that service. When I say it's unethical, I'm quoting the American and the Canadian College of Obstetricians and Gynaecologists. They have very clearly delineated what the physician's ethical responsibility is to a patient when the patient comes and says, particularly in the area of abortion, 'Doctor, this pregnancy is unwanted. Help me.' The physician's duty and responsibility is as an advocate for the patient. You are not allowed to put your own personal, moral perspectives ahead of the patient. I am not pro-life or pro-choice. My technology is not pro-life or pro-choice. My services are not pro-life or pro-choice. They are, as they should be, ethically pro-patient.

Mehfil: Why is it that you advertise in the Indian media?

Stephens: "The first thing is, I don't exclusively advertise in the Indian media. I don't 'ethnically target' anybody. That's a term the media has coined. The media has found a way to put a moral slant on the way that I medically, legally, and ethically make available knowledge about who I am, what I do, and where and when my services are available. The way the media presents it, they are in fact creating a form of ethnic targeting and, I would say, racial discrimination by saying this is what I'm doing. I think it's important not to use the term ethnically targeted. What I'm doing as a businessman, and if you're not a good businessman you're not a good physician, is to simply let the people who have

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expressed an interest, a wish, and a desire for my services know who I am, where I am, what the services are, and how they can be accessed.

Mehfil: You do realize that the perception is that the Indian community uses your services because there is a desire to have males over females.

Stephens: "I am not a community service. I am a physician. I am in medical practice and I see patients. I have a one-on-one doctor-physician relationship with every individual that I see. I am not supported by, sponsored by, or any way encouraged by any motivation other than providing a medical, legal, and ethical service which provides diagnostic information using ultrasound by sonogram. Therefore, to say that the community wants or needs this service, as far as I'm concerned, is a political statement. I have no connection with any community. I just have relationships with individual patients, where it is medically appropriate or necessary. To say that the Indian community just wants boys over girls, that's not fair. That is racial discrimination against the individuals who come to see me, who have a personal, private reason for wanting to know if the baby is a healthy boy or girl. To try to characterize this as an Indian community's cultural need to just have boys over girls is not the truth of the matter. It is slandering Indian women and Indian couples . . . it's slandering the individuals that come to me.

Mehfil: People have this perception that Indian couples visit you, they find out it's a female and they abort the fetus. What is your experience?

Stephens: "Let me give you an example. I'm not going to give you specifics and it's unfair to make generalizations. If you are planning to have three children, then it's not unreasonable to have those three children wanted according to what the latest technology can provide you with. There will be social, economic, cultural, personal, and familial wishes, needs, and desires there. In the Mexican experience, they don't come forward and have pre-natal diagnosis, amniocentesis, to find out if the baby has Down's syndrome. A child with Down's syndrome is accepted into the family in Mexican culture. They don't want to terminate the pregnancy. Those children are wanted. Yet there's a whole industry in the West, in so-called developed countries it's called pre-natal diagnosis, where you do amniocentesis and now that information can be obtained early. And that whole industry is to allow people to find out if the baby does or doesn't have Down's syndrome and on that basis to want or not want that pregnancy and have a termination. So there's two cultures. Now I can go through different cultures and give additional reasons . . . you would eventually realize that in a doctor-patient relationship, it's really individuals who determine whether or not a child-to-be is wanted or unwanted. I feel that it is very important to separate my services from the whole area of abortion because I don't do abortion counselling, I don't offer abortion services, and I don't refer people for abortion. However, as an ethical practising physician, if you ask me information about abortion, I will give you a telephone number where you can get that information. That information may lead to counselling, that information may also lead you to being able to obtain abortion services. I don't discriminate against patients in an area where it may be that I personally am not pro-choice.

Mehfil: Do you think some people come and misuse the ultrasound medical test? How do you feel about this on a personal level?

Stephens: "How do I separate myself personally from a practising physician? I've explained to you, it's your ethical responsibility and duty. And the way I do that, I don't do abortions. That's one way. I mean I could. In fact, when I was in my training and when I did pre-natal diagnosis exclusively, that's what I used to do. I would do amniocenteses, diagnose Down's syndrome, and I'd counsel you. I would counsel you before you had the procedure, I'd counsel you after you'd had the procedure done and you got the result and wanted to have an abortion. I then did the abortion. But I've chosen, in this field of endeavor, to not perform or provide abortion services, leaving it up to the individual to decide if the process is wanted or unwanted and allowing them to make the decision as to how to pursue handling that situation after they see me separately. That's the first issue. The second one is, do people abuse the services? Well, how can you abuse a service if you're coming forward fully knowledgeable and fully recognize that you're the only person that can make this decision in this family-planning area of decision-making? I can only put it back to you as a question. Is it an abuse of a technology or a technical ser-

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vice to plan your family according to your own personal needs? Is it an abuse to limit the size of your family, the number of children — is it an abuse to be responsible to children that are wanted versus children that are unwanted? If you turn it around the other way, perhaps there are people that have more children than they should, produce children that are unwanted. Then the logical step after that is that when children are born that are unwanted, they're at a greater risk for being abused. Less risk than children who are wanted, cared for. I can only see social good coming from anything that helps couples have children that they want. . There is a natural wish and desire for all people, regardless of culture, to have a boy and a girl. And when that imbalance in nature, either because they're all boys or all girls or an unwanted number of boys or girls, or any combination . . . .

Mehfil: In the last answer you said that you don't see anything but social good coming out of family planning. Of course there are a lot of cultural influences that come into play.

Stephens: "If I was a Catholic and a follower of the Pope, I would believe that all conceptions should lead to all children being born. As a consequence of that, we've gone from two billion people in the 1940s to five billion people. We've more than doubled the world population in 30 years. Now, is that social responsibility?

Mehfil: It's no secret that female fetuses are aborted in India at a rate of 3,000 per day. It's no secret that we are a male favoring community. Family planning at the expense of females — how is that social responsibility?

Stephens: "You have to look at the long term view, and the long term view is that individuals are much smarter than any newspaper reporter, much smarter than any physician, much smarter than any societal engineer . Because you don't have daughters, you won't be able to have sons and your generation will stop — real simple. In the long term view, people are smart enough to realize that just having sons isn't going to work."

Mehfil: You have what I call the "Jekyll and Hyde" image in this community. Do you have any thoughts on being such a liked and hated man?

Stephens: "Who hates me? The patients that come forward to see me are free to do that. You usually find that where there's a quality service, you get what you pay for. In this case, you are getting one hundred per cent accuracy in terms of the gender determination. You're also getting the medical perspective, which is not one hundred per cent. You also have physicians who refer patients or make it possible for people to access my services. They like me. Who doesn't like me? The ones that have come forward are expressing their own personal views. The people that are creating this perception of Jekyll and Hyde are people who in my opinion are politically motivated."

[redacted] *How much do you charge?*
Stephens: "Oh, it's well known. I charge $1100."

[redacted] *And how many clients do you have per day?*
Stephens: "That's between me and the Internal Revenue Service."

[redacted] *I know that you do not appreciate that people have made it a race issue, but I think that the Indo-Canadian community would want to know what per cent of your clientele is made up of people from our community.*
Stephens: "I think it's irrelevant."

> **"The services in the office out of Blaine are for couples who want to find out two basic things — is the baby healthy, and is it a boy or a girl."**

[redacted] *You are a person who can give us, as a community, insight into our cultural practices. Do you see female infanticide as a problem in our community?*
Let me put it this way. Men, women, and physicians — Indo-Canadians — tell me that my services are essential. They want it, they need it, and greatly appreciate it. What more endorsement do I need personally and professionally other than the fact that people say thank you? Physicians have even come forward. There was one physician who publicly allowed himself to be interviewed on a call-in radio program on CKLG, a program called *Under Appeal.* He said, 'Look, I'm an Indo-Canadian. The majority of my practice is Indo-Canadian, and it's discriminatory to say that Indo-Canadian women are incapable of deciding what's best for them, what they want, and how to use technology. They are intelligent and educated. These are personal, private issues.' He also said people don't abuse these services. Who else can, or should, or needs to come forward with endorsements? And the fact that I've been here running this clinic since May 1990, despite all the attempts to make me disappear or make me go away, despite the efforts and attempts to create the perception that my service is unnecessary or unwanted or inappropriate . . . . I'm still here twice a month and it looks like I'll continue to be here until some time in the future. ❒