Bystander role of professionals: ethical considerations. beyond medical practice

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Dr. Pilgaokar is on our editorial board. He serves several organisations working for human rights. He focuses attention on the inaction al -too-commonly displayed by medical professionals in the face of crises.

Man-made crises

'Crisis' is often a consequence of sustained neglect. When the neglect is in the form of a bystander role adopted by health professionals it must be considered wilful violation of ethical principles. Whilst medical ethics concerns itself principally with the practice of medicine, we cannot ignore our duties in the prevention of disease and endorsement of health.

Recent events in and around Bombay tell a sad story.

The plague

As I write this, the first patient with bubonic plague was detected in Beed district of Maharashtra two months ago. The first case of pneumonic plague was seen in Surat (Gujarat) over four weeks back. It took over 30 deaths and panic in the affected areas (with repercussions in Bombay, Delhi and several other Indian states and the imposition of international sanctions against India) before the issue of hygiene and prevention of disease were taken up in earnest.

Whatever the reasons politicians in power may have for lack of urgency in the early stages of such crises, professional ethics ought to have compelled medical doctors to have made their concerns heard by the state and, failing it, by the people, in whose 'interest professional pursuits exist. (The only evidence we have of such prompt ethical concern is from the'doctors in Surat headed by Dr. Pradip Pethe. They cornered ministers and officials from Gujarat and New Delhi and served them unpalatable facts.)

Concern for prevention and control of infectious diseases has been progressively eroded. The enthusiasm displayed by a Haffkine or a Sokhey is no more evident in the second most populous city in the world. (Is this because there is no scope here for raking in millions of rupees?) For a population. of 10,000,000, Bombay provides innumerable ICCU (intensive cardiac care unit) beds, but can spare just a few for infectious diseases including tuberculosis. Whilst the ICCU beds are predominantly in the private sector, those for infectious disease remain in the much-maligned and neglected public sector hospitals.

Kasturba Hospital for Infectious Diseases remains the only refuge for patients with plague, cholera or any other communicable illness in Bombay. The role once played by the hospital for tuberculosis at Sewri is being progressively degraded even though this disease is on the upswing and will pose a worsening threat as the incidence of AIDS rises. Neither hospital is equipped with the best in the form of staff, equipment, laboratories and other facilities for treatment and research. The Haffkine Institute, an international reference centre for plague and the workplace of Dr. Waldemar Haffkine, is in shambles. Once the only source of the vaccine against plague, it is now driven to seek vaccine from Russia - vaccine subsequently. found to be unusable! (Was no attempt made at establishing its adequacy before placing the order?) The Institute has just started providing its own vaccine, several weeks after the onset of the epidemic. This vaccine, dated 1989, had to be tested elsewhere in the country, the Haffkine Institute having lost its own ability to do so. An expert claims that it may prove inadequate, given the mutations that the plague bacillus may have undergone over the past five years.. Could Haffkine Institute not have produced the vaccine using samples of the plague bacillus from the early cases in Beed?

Elsewhere, such institutes would have been carefully nurtured and developed into internationally reputed centres constantly at work at the frontiers of knowledge.

Death of new-born infants at the Cama and Albless Hospitals

It was necessary for fifteen new-born infants to die from infection acquired in hospital in a span of one month and the subsequent expose in newspapers before

the authorities at the Cama and Albless Hospitals awakened. The wards were closed down and patients dispersed elsewhere. Subsequent events can be confidently predicted. Each one responsible for the efficient functioning of the hospital will disown any suggestion of guilt. Powerful tugs on appropriate strings will ensure that no heads roll. In time the public will forget these infants and 'work will continue as usual'. The events following the tragedy produced by adulterated glycerol at the Sir Jamsetjee Jejeebhoy Hospital and inaction on the report by Justice B. Lentin are fresh in many minds.

As with the glycerol tragedy, so with the deaths at Cama and Albless Hospitals, the organisations of medical practitioners and the Medical Councils have expressed no anxiety, conducted no enquiry, highlighted no malpractice. Uncontested reports in the media of deplorable sanitary conditions at the hospitals (filthy kitchens next to stinking sanitary blocks), substandard administration and incompetent medical care do not appear to move the individual or collective medical conscience.

Why did doctors working at the Cama and Albless Hospitals accept a situation where such a tragedy could occur? Why was it necessary for **fifteen** babies to die? Wasn't the first death sufficient cause for heartburn, investigation and action? Weren't the second, third, fourth deaths sufficient proof that something was terribly wrong? Are deaths in this hospital analysed by a committee? (Are they analysed at all other hospitals?)

Stinking toilets are ubiquitous at all our public institutions. Hospitals conform to this rule. Because of this all-pervading state, it is mistaken as the norm. There appears to be no urge to correct the situation. At a recent seminar on 'Improving public hospitals', an administrator of a public hospital said that it is upto the public to keep them clean, disowning any responsibility whatsoever on her part. That these toilets are the property of the institution and poor hygiene in and around them poses danger to the very patients the institution is trying to help did not impress her.

Responsibilities of medical professionals

Responses to crises are reflex, poorly designed and half-hearted. Those at the helm in the departments of preventive medicine and hygiene at the medical colleges in the city of Bombay and, indeed, the state of Maharashtra have decided to adopt a bystander role, watching coolly the ever-worsening situation.

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Pvt. doctors flee Surat

By **Rafat Nayeem Quadri**
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A large number of doctors doing private practice here have fled the city closing their clinics and hospitals. This phenomenon is more pronounced In Rander Road, Katargaam and Ved Road areas, which are among the worst-hit segments of this city.

Heaps of stinking garbage are commonplace in almost all our cities. Urinating and defecating males are commonplace sights on the Bombay roads. We have let malaria spring back with a vengeance through neglect. Outbreaks of hepatitis and parasitic infestations evoke no surprise. Now we are witness to infants dying from insanitary conditions in hospitals and the spread of a preventable disease such as the plague.

By failing to indict the authorities who should be concerned with public health but have showed neither the will nor the energy to tackle the root cause of preventable disease, medical professionals must share their guilt. They could not have missed the grave warning that the first case of plague provided to the rodent infested cities of Maharashtra. No attempt was made at monitoring the movements of our vast floating population in and out of the districts affected by plague till the newspapers featured plague on their front pages. By then, as we now learn, individuals had already travelled to Orissa, Bengal and New Delhi with especially devastating consequences in our national capital.

The currently fashionable mantra - 'privatisation' - has so entranced our politicians within and outside the medical profession that our pioneering institutes, built by the labour and skill of outstanding scientists, have been allowed to wither.

Each professional enjoys a privileged status based on special skills and abilities. Such privilege carries [illegible] professionals are

obliged to act, in consonance with the principles of beneficence, compassion and justice. These principles must be applied not only to the individual patient seeking help but also to society at large. The doctor-patient relationship must be complemented by that between the profession and society. The bystander role adopted by medical doctors is unethical, immoral and a dereliction of duty.

Thus far neither has the medical profession at large nor have the Medical Councils uttered a word against those doctors who fled Surat at the early indications of plague. It was left to the citizens to take the law into their own hands and show their outrage against these cowards. Is this what doctors and the Councils desire as the pattern for the future?

The role of the doctor in legal executions

Kannamma S. Raman

Dr. Raman is Assistant Professor of Political Science, Sophia College, Bombay. She discusses an inspiring example set by a doctor of Indian origin in the U. S. A. The suggestion at the end of her essay needs urgent attention.

The presence of a medical doctor, charged with the saving of human life, at the legal execution of a fellow-being has disturbed many within and outside the medical profession. Most countries mandate such attendance and subsequent certification of death of the condemned person. In the event the convict is still alive, the doctor must recommend a more effective measure to kill him.

Such laws place the doctor in a cruel dilemma. The traumatic experience may haunt a sensitive physician for the rest of his life. In America, the problem is complicated by the fact that though the electric chair was created with the goal of making the execution less inhumane (as death was supposed to follow instantaneously upon the administration of a high-voltage current), in fact the convict may be subjected to agony that may be prolonged for thirty minutes.

The Hindu, in a report dated 2 May 1994 [1], reports an important ruling by the American Medical Association (AMA). A doctor's participation in an execution constitutes a violation of medical ethics. Mr. Arthur Caplan, director, Centre for Bioethics, University of Pennsylvania, explained that doctors "...should not participate in execution or use their medical skills basically to punish people..."

Acting on this ruling, Dr. Balvir Kapil, Chief Physician, Department of Corrections, Richmond, Virginia refused to attend the execution of Timothy Spencer, convicted for rape and murder of four women This case had already generated publicity as Spencer was the first person to be sentenced for execution in the USA on the basis of genetic finger-printing. Without DNA collected from tissue samples at the scene of the crime, Spencer could not have been prosecuted as there were neither eye-witnesses to the crime nor circumstantial evidence.

Dr. Kapil is the first doctor in the USA to refuse to participate in the execution after the AMA ruling. In his absence, Dr. Alvin Harris, a private practitioner also working at the Correction Centre, filled in the death certificate [2]. Dr. Harris argued that the AMA ruling was in conflict with state law.

Dr. Kapil was transferred to another department because of his refusal. The American Medical Association's response is awaited.

This development has important ramifications in the Indian context. This is the time to re-examine the medical practitioner's role with reference to prisoners in general and those sentenced to execution in particular. What should the doctor do when faced with a victim of torture by the police, security forces or other arms of the government? Is it his duty to make public the facts whilst treating his patient? To what extent is a medical professional obliged to accept governmental orders implicitly?

The Indian Medical Association and other bodies such as Forum for Medical Ethics should, at the outset, initiate a national debate, on this vital issue. The outcome of this debate may also have a positive impact on the move to outlaw capital punishment and execution from civilised society.

References

1) Anonymous: Indian doctor refuses to play Yama. ***The Hindu 2*** May 1994, page 11.

2) Anonymous: Doctor's dilemma. ***The Hindu 4*** May ***1994,*** page 12