ments that went against the accused doctors had been deleted. No doctor sitting on the panel was a cardiologist or cardiac surgeon though my case was related to cardiology.

Once the verdict is passed against you in the medical council, it becomes very difficult to get it amended as it is a decision of a body of medical experts. There appears to be no point in filing a case at the medical council. It may be better to file a civil suit or go to a consumer court.

The lay person and the Consumer Protection Act[8]

There is good news for consumers as yet another hurdle in matters of medical negligence has been removed thanks to Justice Balkrishna Eradi, president. of the National Consumer Disputes Redressal Commission. Consumer courts will not admit a charge unless there are expert medical opinions stating that the complainant has made a sustainable case. The only exception thus far has been in cases where medical negligence is obvious to the lay person.

When Justice Eradi's attention was called to the fact that patients and their families experience difficulties in getting the requisite medical opinions, he ruled that in such cases, the consumer court will seek the opinion of experts attached to renowned public or private hospitals. He stated that under no circumstances should complaints of medical negligence be dismissed by consumer courts for want of an expert's opinion. If a court does dismiss a case on such grounds, the consumer should immediately go into appeal against the order.

Justice Eradi also ruled that doctors accused of malpractice and the complainant must be granted the opportunity of cross-examining witnesses. Where such an opportunity has been denied, the National Commission should be approached for redressal.

The opinion given by a medical expert witness can be used only as a guide by the presiding judge and is not binding upon him. It merely unravels the medical intricacies for the judge.

References

1. Anonymous: Pregnant woman falls victim to quack in south Delhi. ***Indian Express 23*** May 1996 p 3.
2. Gillon Raanan: Sometimes we have a duty of care not to intervene. ***The Guardian*** (U.K.) ***7*** March 1996 Online Supplement p 12.
3. Marpakwar Prafulla: Has DMER misled Govt over dot-criminal nexus in JJ Hospital? ***Indian Express 30*** March 1996 p 9.
4. Press Trust of India: Medical board to examine Chandraswami. ***Indian Express 16*** May 1996 p 9.
5. Anonymous: Judge rejects report on Chandraswami's illness. ***The Times of India*** 18 May 1996 p 8.
6. Fein Esther B: Verdict on suicide raises questions in USA New ***York Times.*** Reproduced in ***The Times of India*** 10 April 1996 p 14.
7. Raheja RG: No justice from the medical council. ***The Asian Age 8*** June 1996 p 11.
8. Deshpande Shirish V: Justice is now a bit more accessible with CPA. ***Bombay Times (The Times of India) 12*** June 1996 p 5.

FROM OTHERJOURNALS

Acquire organs for transplantation[1]

James Childress, Kyle Professor of Religious Studies and Professor of Medical Education at the University of Virginia, well-known to us as co-author (along with Beauchamp) of the four principles of biomedical ethics, beguilingly confesses, at the start of his essay, on how he was seduced, twenty-five years ago, by the emerging field of bio-medical ethics. The occasion was an interdisciplinary seminar organised by the faculties of law and medicine on 'Artificial and transplanted organs' at the University of Virginia. This led to the publication of his oft-quoted paper 'Who shall live when not all can live?'

In the section on language of organ transplantation, Childress discusses such problematic terms as 'harvesting', 'salvaging', 'procurement' and 'retrieval' of organs and of the widely used term 'donor' referring to the cadaveric 'source' of organs as well as to the person making the decision on donation. One who sells an organ cannot be termed 'donor' but must be referred to as 'seller' or 'vendor'.

When considering the sale of organs, we need to consider its 'ethical acceptability' and its 'ethical preferability'. Two or more practices or laws may be ethically acceptable but only one may be preferred on ethical grounds. We must also look at whether it is feasible. An act may be ethically acceptable and preferable but might fail the test of feasibility. A policy might gain approval in legislatures and courts but may not find favour with institutions, professionals, families or individuals. Eliciting cooperation is very complex on account of emotions, sentiments and beliefs that are often tied to rituals and communal practices. Policies that appear eminently rational may fail if they do not take into account the symbolic significance of the human cadaver.

Possible 'owners' of the human cadaver and its organs include those to whom the deceased person willed his organs, the family and the community at large. These owners have the rights to possess, use, exclude others from and destroy or transfer these organs. The National Organ Transplant Act (1984) in the USA made it 'unlawful for any person to knowingly acquire, receive or otherwise transfer any human organ [defined as human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone and skin] for valuable consideration for use in human transplantation...'

Arguments supporting the sale of organs rest either on the principle of respect for autonomous choices or on that of utility for human welfare. The main objections to these are: 1) There are risks to live vendors; 2) there are concerns about the vendor's lack of voluntariness, especially if they be poor; 3) buying and selling depersonalise and degrade the seller and society. Those defending sales argue for regulation rather than prohibition.

Hippocratic oath revisited

Our readers may recall studying the suggestion made by Dr. Eugene Robin on the need for revising the Hippocratic oath to keep it relevant[2]. Robin and McCauley have continued their campaign in other journals, hoping to gain general acceptance of the updated oath.

The recent publication of their advocacy and comments on the cultural lag in accepting the eminently rational revision[3] sparked off criticism from Hippocrates' own country[4], defending the original oath and refuting the modern version. In a soon. to be published reply[5], Robin and McCauley point out that whilst the original oath remains admirable, it was intended as a code for interaction among a group of males pursuing a common profession. The revised oath puts the patient first and the profession second. It also emphasises the partnership between patient and physician towards the goal of affording an improvement in the quality and, if possible, quantity of life. Since most medical care is now offered not by an individual but a team, the revised oath also embraces personnel other than the physicians. In their reply, Robin and McCauley also caution against a feeling of superiority in the medical profession which can only work to the detriment of the patient. Their suggestion that the International Hippocratic Foundation sponsor a meeting on the oath to which representatives of the poor and uneducated are also invited is unlikely to meet with a favourable response from individuals who deem the oath sacrosanct.

Hippocratic oath revisited (continued)[6]

McHugh's essay is an adaptation of an address delivered by him at the Johns Hopkins Hospital. We are indebted to Dr. A. M. Pai, Department of Pathology, Tata Memorial Hospital for drawing our attention to it.

As with Robin and McCauley and other authors, McHugh (Henry Phipps Professor of Psychiatry at Johns Hopkins) was struck by the fact that the Hippocratic oath recited by graduating students seemed odd and even ironic in the context of the increasingly nebulous ethical standards in medicine. Since oaths are not directives, they reflect the goals being set by those taking them based on clear principles.

Recitation of the Hippocratic oath at Johns Hopkins was revived in the late 1960s at the request of the students who wished to imbue the graduation ceremony with solemnity. At their request, Professor Owsei Temkin - himself not a believer in oaths - provided a translation. When the graduating class of 1968 read the oath, minus the invocation of pagan gods and the reference to lifetime family partnership with teachers, there was an uproar - not from the students but from the teachers who were dismayed by the clause on abortion. Subsequent readings omitted this clause and the admonition against the knife.

McHugh presents the texts of the classic Hippocratic oath, the Johns Hopkins version dated 1985 and that dated 1994. The contemporary meaning of 'vice' as sexual immorality is employed. The roster of gods and goddesses is omitted. The number of promises to fellow practitioners has been reduced.

McHugh feels that in the process there is a loss of tough-mindedness. There are also traces of self-absorption in the modern versions at Hopkins. Changes such as the omission of 'generous' (towards one's fellow physicians) and the substitution of 'no operation without justifiable purpose' for the earlier 'no operation for a criminal purpose' are also criticised. There is an attempt at avoiding the charge of sexism, 'men and women' being substituted for 'men'.

Students at Harvard University went one better. Instead of modifying the oath named after Hippocrates, they have written their own 'Graduate Oath'. McHugh provides the 1989 and 1994 versions and points out that these are even more ambiguous than the Hopkins oaths and enlarge the commitment to self-interest. McHugh is especially severe on the substitution of the phrase 'the benefit of the sick' by 'for the service of humanity', pointing out that Nazi doctors, the zealots of euthanasia and the Tuskegee scientists (notorious for the observation of 'natural history of syphilis' after withholding treatment) claimed to serve humanity.

McHugh commends the study of such oaths as indicators of trends in ethical practices. He also suggests some rethinking. 'Professor Temkin was right. If this is the outcome, medical students should stop reciting - and certainly stop writing - oaths. They are so confused about their ethical aims, so mixed up in the sources of their ideals, they should stop talking about them in public.'

Ethics in journalism[7]

Many of us have to deal with journalists in our capacities as medical experts. We are called upon to offer opinions on matters - often controversial - pertaining to health care. Most such opinions were, earlier, requested in writing, the entire text provided by us being published under our authorship. There was little room for confusion. These days, journalists are prone to seek opinion on the telephone on account of deadlines set for their 'story'. Though the queries may be brief and specific, the answers must, perforce, involve reference to statistics, probabilities and alternatives (in diagnosis, therapy.. .). As most journalists appear to poll a wide range of doctors, what eventually appears in print is often a disjointed series of quotes, sentences being isolated from the context in which they were made. Such experiences have raised doubts in the minds of doctors on the principles under which journalists operate.

Glasser's essay makes excellent reading and provides much material for thought not only for journalists but also for all those amongst us who must, from time to time, interact with them.

Glasser is director of the graduate program in journalis S an

University. In his essay he refers to the principles enunciated by Jurgen Habermas, the German philosopher, Immanuel Kant, John Rawls and others. In doing so, he provides insights on ethics in general as well.

An example of the manner in which Glasser stimulates thought is the distinction he makes between 'what justice **is'** and 'what justice **demands'.** Justice may demand a verdict but at least as important is the manner in which that verdict was reached and whether that verdict was used to justify cruel and inhuman punishment - 'what justice **is'.** He also contrasts Kant's 'categorical imperative' wherein moral precepts apply irrespective of circumstances by virtue of forming universal laws and Rawls' principles of justice tailored to the needs of modern constitutional democracies. Rawls enunciated three broad principles: that of greatest equality (every person to have an equal right to the most extensive total system of equal basic liberties), that of fair equality of opportunity and the difference principle where social and economic inequalities are so arranged that they are of the greatest benefit to the least privileged.

Habermas conceived communication as based on the rules of access, argumentation and justification. Access stipulated that all individuals capable of communication must be allowed to communicate. Argumentation ensured that all individuals be allowed to introduce any proposal or assertion, call into question any proposal or assertion and express their attitudes, desires and needs. Justification implied measures to ensure acceptance of every moral claim by all individuals.

Glasser points out that codes of professional conduct can amount to little more than group egoism when they treat professional obligations as nothing more than what the profession says it is without gaining the acceptance of society at large.

In concluding, Glasser makes the telling observation that 'newspaper ombudsmen, who often function as the only source of local press criticism, find it more important to take issue with the conduct of reporters than to criticise the conduct of editors, publishers and other media managers. '

Genetic privacy[8]

The winter issue in 1995 of *Journal of Law, Medicine & Ethics* features a symposium entitled 'The genome imperative' . The first paper discusses the extent to which genetic information can kep Gostin discusses how genetic material is collected with unique identifiers and potential links to identifiable persons to create genetic data bases. Whilst there are obvious clinical and public health benefits, Gostin injects a note of caution as this information can wield considerable influence with employers, insurers and the justice system. Society must control this information without stifling the potential it offers for human good. (See also Wendy Parmet's comment on the pitfalls of legislating for privacy using the analogy of current experience with AIDS - pages 371-374 - in the same issue. Her opening sentence is riveting. ‘Information al ways creates temptations.‘)

Making predictions in children: boon or bane?[9]

The second paper in the symposium referred to above is of equal interest. Since it is now possible to test children and even neonates for genetic DNA abnormalities (such as the tendency for developing cancer of the colon, breast, thyroid) that will manifest years or decades later, should this be exploited for the benefit of all children? Already recommendations are being made that a geneticist has a medical and legal duty to inform parents of the availability of such tests and recommend them.

The authors support those who urge caution and restraint in administering such tests. Pros and cons for tests for specific diseases such as alpha$_1$-antitrypsin deficiency, cystic fibrosis and Duchenne's muscular dystrophy are discussed in some detail. The difficulties in determining the precise benefits from such early diagnosis are weighed against the psychological problems and burden imposed by the knowledge of the inevitability of a relentless disease. Other aspects discussed include the role of the child in giving informed consent, the need for intensive care and support (by whom and at whose cost?) once such a diagnosis is made and safeguards necessary to protect children to ensure accurate and informed decisions,

Other contributions include essays on legislation. The entire symposium deserves careful study.

Doctors assisting in suicide[10]

‘On November 8, 1994, Oregon became the first state in the (U.S.A.) to legalise assisted suicide.’ This essay discusses such issues as whether assisted suicide should be established as a constitutional right, placing pros and cons before the reader. Many will heave a sigh of relief on reading that ‘most people vastly over-estimate the number of terminally or chronically ill individuals who actually want to take their own lives...Once patients are confronted with illness, continued life often becomes more precious; given access to appropriate relief from pain and other debilitating symptoms...’

Can organs be harvested from an anencephalic fetus before its legal death?[11]

Reagan poses this problem in the context of an actual case and presents the discussion on the various pros and cons by the hospital ethics committee. At first thought it would appear that there should be no objection to the harvesting of organs from a fetus that stands no chance of meaningful survival. The ethics committee based its decision on the basis of the law as it stands and saw the issue as whether it was morally permissible to kill this fetus for organs.

This paper and the one by Orentlicher that follows make required reading for all those dealing with malformations that make life meaningless.

Is *‘resuscitation’ of a brain-dead person justified?*[12]

A fifteen-year-old boy suffered an attack of status asthmaticus during which he suffered prolonged cerebral anoxia. All clinical and technological tests showed brain death. The boy's mother refused to believe that her son was dead or that he would not recover and refused to consent to a do not resuscitate order. She reprimanded those medical attendants who told her that her views were unrealistic, saying that her religious beliefs included miracles.

The boy was kept alive by artificial means for six months when he was transferred to another hospital where this detailed discussion on the ethics of turning off all resuscitative measures took place. This makes compelling reading. The advocacy of ‘always treat the family, not just the patient’ had led to the adoption of extraordinary measures at keeping the brain dead boy physically alive because the mother had become the primary concern of the medical attendants. It was to assuage her feelings that the ventilator and other measures had been kept going. The authors argue that no one could ever have granted this mother's wish for her real wish was for the impossible. To continue resuscitation under such circumstances was wrong for these measures are intended to prolong life and health, not treat the dead.

The bill permitting doctors to assist suicide in terminally ill individuals in the Northern Territories of Australia[13]

This is the full text of the epochal Australian legislation. Crucial definitions are incorporated within the act. Thus, to assist the proposed death of the patient includes the prescription of the agent that will cause death, the preparation of such a substance and its actual administration.

The conditions under which the medical practitioner may assist death are clearly enunciated. ‘The patient is suffering from an illness that will, in the normal course and without the application of extraordinary measures, result in the death of the patient...In reasonable medical judgement, there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure...,Any medical treatment reasonably available to the patient is confined to the relief of pain and/or suffering with the object of allowing the patient to die a comfortable death...’

It is pointed out that the doctor ‘...is not under any duty, whether by contract, statute or any other legal requirement, to participate in the provision to a patient of assistance under this Act, and if a health care provider is unable or unwilling to ... (assist) and the patient transfers his or her care to another health care provider, the former health care provider shall, on request, transfer a copy of the patient's relevant medical records to the new health care provider.’

The form to be signed by the patient is as follows:

‘REQUEST FOR ASSISTANCE TO END MY LIFE IN A HUMANS AND DIGNIFIED MANNER

‘I,............ have been advised by my medical practitioner that I am suffering from .... an illness which will ultimately result in my death and this has been confirmed by a second medical practitioner.

‘I have been fully informed of the nature of my illness and its likely course and the medical treatment, including palliative care, counselling and psychiatric support and extraordinary measures that may keep me alive, that is available to me and I am satisfied that there is no medical treatment reasonable available that is acceptable to me in my circumstances.

‘I request my medical practitioner to assist me to terminate my life in a humane and dignified manner.

‘I understand that I have the right to rescind this request at any time.’

Living wills - beware![14]

Stone's essay cautions those intending

to make living wills. The abstract is unambiguous. '. ..Living wills are typically nebulous and confused documents that do not effectively enable you to determine your future treatment. Worse, signing a living will can end your life in ways you never intended, long before you are either incompetent or terminally ill. The danger is compounded by the fact that those who implement living wills are often themselves confused, so that, for example, they cannot be relied upon to distinguish living wills from DNR orders. ..Advance directives concerning resuscitation are often so confused that they end the lives of healthy, alert people who have not suffered cardiac or pulmonary arrest.. .'

Stone provides several examples,,. using commonly used formats.

The paper deserves wide attention and close study.

Informed consent in research' [5]

Another essay in a similar vein cautions researchers against '...minor violations of the truth for the sake of access to greater truths.. .' Truth needs no shading. The very fact that a researcher finds it necessary to accept what is for him a 'minor violation' immediately sets him off on the wrong foot for the definitions of 'minor' and 'violation' then assume astonishing elasticity always in favour of the researcher.

Bok also attempts to reorient the researcher into ensuring scrupulous honesty not only in reporting results but also in every other aspect of the study including the manner in which data is obtained.

The example quoted on page 6 is especially effective.

If we are to ensure 'the trust-worthiness of human assertion', any deviation from the truth is unacceptable and must be condemned.

'We are misinformed often enough, blunder often enough, shield ourselves enough and live in deep enough self-imposed shade. We must not add to those forms of distortion by intentionally choosing to engage in deception or self-deception.'

Euthanasia in China[16]

Dr. Cong Yali of the Department. of Social and Human Medicine, Beijing Medical University describes the trial of Dr. Pu Liansheng for prescribing 'Wintermin compound' to cause the death of a 59-year-old women with cirrhosis and infectious diseases who, after deterioration in her clinical state, kept crying that it was so painful that she did not want to live. The court ruled that even thought the compound has hastened her death, the dose was not excessive and found the doctor not guilty.

Dr. Yali concludes that there is a gradual change in the attitude of the Chinese people towards euthanasia. "In practice, euthanasia is often done in secret... I believe we can come to some common understanding which will constitute a base for universal bioethics, in which there is an ethical foundation for euthanasia.'

Two other essays in the same issue deal with other aspects of euthanasia. Dr. Frank Leavitt, an Israeli ethicist, pleads for discussion on the basis that 'bios' means life. 'Bioethics should be the ethics of life. What is life? What is the meaning of life? How can we live healthy lives?...I believe that more emphasis on these questions may result in fewer requests for euthanasia.'

Dr. Darryl Macer and three Japanese colleagues discuss Japanese attitudes. They found the discussions on whether life should be terminated to be more open in the university hospital than in smaller private clinics. In a case decided in March 1995, the Yokohama District Court ruled that four conditions must be met for euthanasia: 1. The patient must be suffering fron unbearable physical suffering. 2. He must be expected to die soon. 3. He must have expressed a clear wish to have his life shortened. 4. There must be no alternative treatment available for the patient's suffering.

References

1. Childress James F: Obtaining the gift of life: ethical issues in the procurement of organs for transplantation. *Social Responsibility: Business, Journalism, Law, Medicine* 1995;XXI:66-85.
2. Robin Eugene D: The Hippocratic oath updated. *Medical Ethics* 1994;2: *16.*
3. Robin ED, McCauley RF: Cultural lag and the Hippocratic oath. *The Lancet* 1995;345:1422-1424.
4. Marketos SG, Diamondopoulos AA, Bartsocas CD, Poulahou-Rebelacow E, Koutras DA: The Hippocratic oath. *The Lancet* 1996;347:101-102.
5. Robin ED, McCauley RF: Letter to the Editor. *The Lancet* (under publication)
6. McHugh Paul R: Hippocrates à la mode. *Nature Medicine* 1996;2:507-509.
7. Glasser TL: Communicative ethics and the aim of accountability in journalism. *Social Responsibility: Business, Journalism, Law, Medicine* 1995;XXI:31-51.
8. Gostin Lawrence 0: Genetic privacy. *Journal of Law, Medicine & Ethics* 1995;23:320-330.
9. Hoffman Diane E, Wulfsberg Eric A: Testing children for genetic predispositions: is it in their best interest? *Journal of Law, Medicine & Ethics* 1995;23:331-*344.*
10. Coleman Carl H, Miller Tracy E: Stemming the tide: assisted suicide and the constitution. *Journal of Law, Medicine & Ethics* 1995;23:389-397.
11. Reagan James E: Ethics consultation: anencephaly and organ donation. *Journal of Law, Medicine & Ethics* 1995; *23:398-400.*
12. Spike Jeffrey, Greenlaw Jane: Ethics consultation: persistent brain death and religion - must a person believe in death to die? *Journal of Law, Medicine & Ethics* 1995;23:291-294.
13. Anonymous: New legislation. Northern Territory of Australia. Rights of the terminally ill bill. *Monash Bioethics Review* 1995;14:14-22.
14. Stone Jim: Advance directives autonomy and unintended death. *Monash Bioethics Review* 1996;15:16-33.
15. Bok Sissela: Shading the truth in seeking informed consent for research purposes. *Monash Bioethics Review* 1996; 15:Ethics Committees - a special supplement 4-15.
16. Yali Cong: The first euthanasia court case in China. *Eubios Journal of Asian and International Bioethics* 1996;6:61-2.

THE WIZARD OF ID **by Brant Parker and Johnny Hart**