CORRESPONDENCE

The worship of Mammon

I wonder whether the general deterioration in ethical standards is not part and parcel of the new social ethos where everything is judged by the yardstick of monetary wealth. Nostalgia for a bygone era when, supposedly, things were better, must be tinged with the realisation that in those days opportunities and temptations to stray from the straight and narrow path were fewer and less attractive.

I provide an example. For those in government hospitals, at least in Tamil Nadu, there was very little competition from the full time private practitioner. There was hardly any private hospital which could match government teaching hospitals in facilities. The situation has changed dramatically and today it is the private, especially the corporate sector, which is better equipped. A burgeoning middle class has made private medical care an extremely lucrative proposition for doctors. Doctors in government teaching hospitals, permitted private practice, have one foot in each camp and would like to have their cake and eat it too. The unhealthy competition for patients has engendered most medical malpractices.

One specific point worries me. You have implied that it is unethical to treat a patient who is already under the care of another doctor's care without his permission. I feel this is a wrong attitude.

First and most important, does it not infringe on the patient's democratic right to choose whom he will be treated by? Second, how can a doctor in a government hospital refuse to treat a patient who may have initially taken treatment in some private facility? Third, how many doctors, either in the private or public sector, will actually refer patients to another in their own specialty?

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(Sunil Pandya analyses the concept of doctor-patient relationship on pages 23-24. We welcome comments. **Editor)**

On Medical Ethics (1)

I have enjoyed reading your journal. It creates a much needed space to reflect on the proposition that true professionalism cannot be divested from obligations of conduct at any stage. This holds good as much for medicine as for law, the media or business management. This holds good even more in cultures where the knowledge base of the professional is out of line with beliefs and knowledge that people make-do-with in order to cope. No wonder that the interface of each of these professions and its clients is generally intimidating. This is especially so in medicine because of the physician's justified right to intrude into an individual's mental and physical privacy.

The moral is to shore up the competence to take to self-correcting regulation and uprightedness of medical professionals as a group. But given the quadrilateral that many thoughtful physicians agree faces them, viz. the hypnosis of technology, the siren song of commercialism, status uncertainties inherent in infighting and a great decline in eminent role models; physicians, as a group need help and guidance from outside their profession in anchoring conduct to notions of what is right.

Philosophers, historians, social scientists, policy makers, lawyers and others have to understand and empathise with physicians and help resolve the dilemmas faced by them. It is a long haul. We must set modest milestones and do tenacious networking among those concerned with restoring health and human dignity to the centre.

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On *Medical Ethics (2)*

Thank you for the January-March 1995 issue of *Medical Ethics*.

The sad fact of life is that people do not like to be lectured or taught. They prefer to learn on their own, if at all, from what they hear and see. So far as ethics are concerned there are today few who can adopt the EDP approach to engender them; Explain, Demonstrate and Practice.

Journals such as *Medical Ethics* achieve only the E component to some extent and while doing so, as Dr. Reinders remarks in his letter[1], become declaratory, judgemental, didactic.

I do not doubt the intentions of your authors; I only doubt the efficacy of their efforts. It has always been difficult to persuade people to follow the right path. Buddha, Christ, Gandhi - all tried and failed. More sins have been committed in the name of religion that anything else, perhaps all through human history. Isn't ethics (medical, legal, fiscal or any other) included in the wider definition of religion? And if people refuse to be religious (not ritualistic) what reason is there to hope that they will agree to be ethical?

Be that as it may, I admire the zeal and industry of your team. You may think I am sceptical. I am not. I am hopeful. But only if each one of your member adopts a very modest, simple goal: to persuade just one medical person to practice ethically in letter and spirit, in one year. If they succeed in this, you have reason to go on. If they don't, you may have to reconsider the whole project.

What do you say?

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Reinders JS: On *Medical Ethics (2). Medical Ethics* 1995;3: 13.

Students from the scheduled castes

Two statements have been published in two separate articles in *Medical Ethics* Vol. 2, no. 2, Nov. - Dec. 1994 which are open to contradiction.

1. On the Students' Page (page 10) it is said by those who argued against reservation that the doctors from the reserved category were of poor quality with consequent worsening standards and poor service. This concept is absolutely wrong. You will be surprised to know that many medical graduates from the scheduled castes at All India Institute of Medical Sciences did far better than their general category friends. It is not the reserved category candidates that lowers standards. Corruption and a lowering of the medical standards by candidates who pay corrupt examiners are to blame. (See the essay on the Sabnis episode on page 6 of the same issue.)

2. Another point made by the students suggests that only Brahmins and those from other higher castes are intellectuals. This is highly objectionable. Knowledge and intellect are not the monopoly of any caste. Any one, whatever his caste, can perform well if he puts his heart and soul into the effort. I am neither a Brahmin nor from any other

higher caste yet I stood first in B. Sc. (Hons.) in the University.

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Organ transplantation

Kidney transplants - or, rather, kidney trade - is very much in the news. We, in the medical profession, have managed to earn Shylockian sobriquets. What Bangalore or Bombay has revealed is but a symptom of a global malady. The whole gimmicky *enfant terrible* is parented by medicine's ignorance of biolaws and arrogance of technocracy.

No sermon on ethics or investigative committee is capable of curing the transplant syndrome. Hope lies in a wider understanding of the biolaws that govern the utility and the futility of any form of tissue transplant.

The cadaveric transplant program, now on the cards, bristles with almost murderous ethical problems presaged graphically by Dr. Robin Cook' in *Coma*.

What works against any transplant is the unabrogatable individuality of a person, even if the donor and the recepient are homozygous or Siamese twins. Each one of us, as Rene Dubos[2] of the Rockefeller Foundation put it, is unique - unprecedented, unparalleled, unrepeatable. Each of the 100,000 billion cells of a human being is carrying its own sense of self and the ability to recognise the cell of anyone else as non-self. It is this self-consciousness, zealously guarded, that carries the organism, against all odds, through the trajectory of three scores and ten. A human being who is taught not to reject a graft also learns not to reject infection.

Calland[3], a physician from California, underwent serial transplants and wrote, before his death, an autobiographical account about his five transplants and a life in hell. Sheila Sherlock, famed for her text *Diseases of the liver* warns in the latest edition of this work that before a liver transplant is considered the patient and the family must be told of the physical and fiscal consequences. Transplantation is a very expensive undertaking, ecologically and economically.

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2. Dubos R: Foreword in So *human an animal*. Chares Scribner's Sons, New York. 1968. 'Page 7.
3. Calland CH: Iatrogenic problems in end-stage renal failure. New *England Journal of Medicine* 1972;287:334-336.