A view from the West

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This is the first in a more or less regular series of essays to appear in *Medical* Ethics. The series will attempt to provide a critical and relevant analysis of Western medicine not available in current journals. The issues to be discussed are described briefly below. They concern both the Third World and the West.

I **Problems in medical ethics that concern all nations.** Approaches to such problems in India, the United States (USA) and elsewhere will be highlighted.

The central function of medical ethics should be an improvement in the outcome for patients - individual, in groups or in a given population. A better outcome can be defined as an improvement in the quality of life, longevity or both. *Medical Ethics* discusses issues that have broad societal overtones into which physicians have little or no special insight. This is seldom the focus in the USA. One example is physician-assisted suicides. Medical ethics committees in the USA frequently deal with issues that facilitate the use of patients as experimental subjects without ensuring that truly informed consent has been obtained from them.

Pronouncements on medical ethics in the USA are often made on the basis of analyses similar to those used to decide issues in clinical medicine. A group of medical 'experts' is asked to produce a consensus statement, often without insight into the societal overtones of the issues. The result: the development of self-designated medical ethicists propagating their perception of the 'truth'.

If this journal, *Medical Ethics*, is representative of the field of medical ethics in India, we have much to learn from you. The consideration of medical ethics in India seems to involve three steps: i) seek instances of improper medical behaviour that harm patients; ii) describe these boldly and with honesty; iii) attempt to change such behaviour. The relation of the Indian approach to improving the outcome for patients is obvious, This is frequently not so in the West.

The need for transcending all geographical boundaries when considering medical issues is dramatically illustrated by the several thousand unnecessary deaths each year in the USA caused by cyanide poisoning consequent to the therapeutic use of nitroprusside. This drug is degraded into cyanide in the body. There are no such deaths in Germany because of the simultaneous administration of thiosulphate.

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II **The use of risk-benefit analysis to educate physicians, the public and individual patients.** Historically, medicine over-emphasises potential benefits whilst ignoring or underplaying risks. Often it is not possible to quantify the risk-benefit ratio without a properly conducted, randomised, prospective, controlled, double-blind trial. Perhaps less than 10% of currently used medical interventions in the West have been subjected to this rigorous form of analysis. Accidental iatrogenic errors can follow.

Being human, those providing health care do err. Random, non-systematic, unintentional harm is thus done to individuals. The amputation of the normal leg instead of that which is diseased is an example. Withdrawal of ventilatory support from the wrong patient or administration of an incorrect dose of a drug are other examples.

There are some surprising aspects of accidental iatrogenic errors in the USA. i) The vast toll of lives and wastage of sums spent on welfare. Approximately 50,000 patients die and an additional 450,000 patients are crippled each year in American hospitals. Despite this harvest of death and misery, just a small fraction (1%) ever get to the law courts. Even more surprising is that physicians, other health care workers and hospitals are doing so little to reduce the toll. There is much that can be done. ii) Iatroepidemics - systematic, preventable, errors killing or crippling large numbers but widely accepted by the medical profession. One example is the mass screening of males above the age of 50 to detect prostatic carcinoma. This is based on the concentration of prostate antigen in the serum. The fallacies of this approach and its ill consequences will be discussed.

III **Uncovering Western medical imperialism** and finding ways to minimise its risks. Such imperialism stems from the assumption that whatever is developed and widely accepted in the West is automatically the best for all patients everywhere. Young physicians trained in the West are especially susceptible. They accept such 'advances' without critical appraisal and import them to locations where the consequences for the patients can only be disastrous.

The mass use of pulmonary artery flow catheters is an example. Such usage is attended with substantial morbidity and mortality. It is difficult to demonstrate net benefit from such usage and, indeed, the practice is on the decline in the USA. Yet, we are sad witnesses to an increasing usage of such catheters in the Third World where the cost of installing and maintaining such a catheter in a *single* patient can wipe out the annual

income of the entire family. When the risk/benefit ratio is grossly unfavourable, the cost/benefit ratio approaches infinity.

Western countries need to revise their training programs for their own nationals and, more important, for those from countries such as India and the Philippines. Third World countries must also ensure that medical education ingrains into the student the paramount need to look at all interventions keeping in mind local needs and social conditions. There is special need for negating the arrogance exhibited by many Western physicians towards patients.

IV **The importance of randomised, prospective, controlled, double-blind trials** to establish accurate risk/benefit and cost/benefit ratios.

V **The right of the patient to select or reject unvalidated, potentially hazardous forms of diagnosis and treatment.**

VI The general issue of **the autonomy of the patient.** Special emphasis will be placed on the education of patients and the general public so that truly informed consent or refusal is obtained.

VII **Risks and benefits of specific technological approaches commonly used in the West.** One example: Does positron emission tomography scanning for coronary artery disease pose greater benefits than risks for normal adults?

VIII **Cultural, social, historical and economic aspects of medicine** with emphasis on how our two cultures can learn from one another.

IX **True advances.** This series has, thus far, focussed on risks and errors. To that extent it is unbalanced. Western medicine has, of course, a splendid record in saving lives and improving the quality of life. One example is the reduction in mortality from myocardial infarction from 20% to 5% by the use of thrombolytic agents.

X Analysis of new diagnostic and therapeutic modalities as they become available.

It is anticipated that comments, criticisms and contrary views from readers will form an integral part this series.