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Thank you very much for your wishes and I am surc. with the common problems and common struggle, we will manage to change the current state of affairs from bad to good.

We saw only one issue (December 1995) of *Issues in Medical Ethics*. Let me confess, we came up with thc idea of our journal after seeing that issue. We do not have any of your previous issues and do not recievc them too. We will be extremely delighted to be on the mailing list and request you to send copies of earlier issues.

I have sent some copies of our Journal. We havc borrowed some ideas from your journal and I thank you for your offer to lct us usc material from it in future. We will certainly acknowledge it. You can also use any material from our Journal.

I once again rciterate our desire to share our expertise and hope that we can come up with a common goal for the region in the context of medical ethics.

With all the best wishes and looking forward to a fruitful cooperation and friendship,

DR RANA TAUQIR AHMED
PMA House
Garden Road
Karachi 74400
Pakistan

Disregard for medical ethics despite protest

Let me share two depressing experiences about the disregard for medical ethics shown by doctors despite my protest against unethical practices.

(1) Ms. Medha Patkar was on indefinite fast three years back along with a local Adivasi activist, to oppose the Sardar Sarovar dam on the Narmada river. Volunteer-doctors were doing their duty in a relay to monitor the health of these two activists. I took over this task on 16th June, the 14th day of the fast. The health of both activists caused no alarm, yet the government decided to arrest them and forcibly give them intravenous glucose. The police swooped in past midnight on 16th June and forcibly arrested them and their followers. I was allowed to accompany them to the Bombay Hospital. In the hospital, I argued with the resident doctor that it is unethical to forcibly administer intravenous glucose to those on fast. The doctor did not seem to know this simple fact. He later defended his attempt at forcibly feeding Ms. Medha Patkar by saying that her life was in danger from increased concentration of serum potassium. I argued that the serum potassium must first be shown to be abnormally high. This was not done for 12 hours.

As per the guidelines of the World Medical Association, forceful feeding can be justified only when the person on fast is not in a state of consciousness to give consent or otherwise for medical intervention to save his / her life. Here, the persons on fast were fully conscious and there was no medical emergency. Yet the doctors chose to oblige the government by providing medical justification for forcibly injecting glucose into the protesters even though I pointed out that this act violated professional ethics.

(2) The Pune branch of the Indian Medical Association organises annual refresher programmes for its members. In the course of such a programme in 1995, during the talk on obesity in childhood, a number of slides of fully naked children suffering from obesity, were shown by the lecturer, a renowned endocrinologist from Bombay, without masking the identity of these children. Some of them were grown-up, preadolescents. While it was necessary to show the naked physique to demonstrate obesity in these children, the identity of these unfortunate children should have been concealed by masking their faces. This was not done. None of the 300 or more doctors in the audicnce protested in any way, then or later. After the programme, I met one of the office-bearers and pointed out the violation of the elementary ethical principles by such a display of photographs of patients. The response was not encouraging. I wrote a letter of protest to the endocrinologist and also a similar letter for publication - to the monthly newsletter of the IMA, Pune. I asked : 'Would we have liked our own children to be shown on the screen thus without concealing their identities ? . . . The organisers were of course, helpless in this case. But in future, can all researchers bc requested to follow the basic ethical norms in the display of photographs of patients ?'

The editor of the newsletter did not publish this letter. What disturbed me most was the unwillingness to improve, even when the unethical practice was pointed out.

ANANT R. PHADKE
50 LIC Quarters
University Road
Pune 411 016

VOX POPULI

Disastrous 'electro-magneto-homeo-therapy' [1]

A pregnant woman was killed during an abortion in a make-shift clinic in Okhla's Harkesh Nagar in mid-May. Dr. Yashwant Kumar Jha, who runs Jagdamba Clinic in the colony, was arrested and released on bail by a city court. The 'doctor' holds a bachelor's degree in a quaint stream of medicine called electro-magneto-homeo-therapy in addition to being a Registered Medical Practitioner and BMS.

This is the third such reported case in reccnt months where innocent paticnts have fallen victims to quacks in various localities. In earlier cases the womb of a woman was pulled out along with the placenta at Khera Khud village in north-west Delhi. In another case the intestines were removed during operation.

The latest victim is 35-year-old Gayatri Devi. She consulted the 'doctor' on May 13 to get rid of her unwanted one-and-a-half month old pregnancy, saying that she already had three children and could not afford to feed another mouth. The 'doctor' called her at 12 p.m. the next day, assuring her that she would be discharged immediately after the operation. Instead, her body was discovered in the clinic at around 1 p.m. The operation was yet to be performed. She died apparently due to the administration of a wrong medicine as fresh injection marks and blood spots were seen on both arms of the victim. The initial autopsy report indicated that she had died of shock.

(Readers **are also advised to study Dr. Ramdas Ambulgekar's essay elsewhere in this issue. Editor)**

Striving officiously to keep alive [2]

Gillon comments on the case of Thomas Creedon, aged three, severely brain damaged, who was kept alive by artificial feeding and hydration even after his

parents had argued the prolongation of his life was not in his best interest. Thomas died in February before the parents could seek legal intervention.

Gillon points out that it is universally accepted there is no moral obligation for doctors to initiate cardio-pulmonary resuscitation, respirators and antibiotics when these are not in the best interests of patients such as Thomas. In the 1950s, Pope Pius XII explained to anaesthetists that artificial oxygenation by respirator was not morally obligatory merely to prolong life and that respirators could be morally withdrawn knowing that the patient would die if the prolongation of life did not achieve a higher good and was unduly burdensome to the patient.

Gillon argues that feeding through an intra-gastric tube and other medical means for maintaining the hydration and nutrition of such patients - as, indeed, is the provision of air or oxygen - cannot be part of a duty of care to the patient if it cannot benefit the patient, let alone where it is likely to cause more harm than good.

Gillon cautions against considering such inaction as 'starving the patient to death' just as it is incorrect to consider the Pope's recommendation as one to suffocate the patient to death. Almost all patients where prolongation of life is deemed to be not in the patient's interest are comatose or are sedated before the respirator or nutrition is withdrawn.

'The ability to prolong people's lives for their benefit is a wonderful and ever-increasing capacity of medicine. To use it to keep people alive when it does not benefit them, but harms them or others, is in my view to undermine the core of medical morality. '

Doctors abetting artful dodgers [3]

A cursory glance at the official records of the State Legislative Council and proceedings and verdicts of the courts in Bombay leads one to the conclusion that the Director of Medical Education and Research (DMER), Vishwanath S. Yemul, has made wrong submissions to Health Minister Daulatrao Aher by saying that no one is guilty of doctor-criminal nexus in the JJ Group of Hospitals.

The official records of the JJ Hospital show at least half a dozen cases where criminals admitted to the hospital were either discharged or ran away on the day they were granted bail. Asraf Gulam Rasool Patel, under trial for criminal offense, was admitted to JJ Hospital on July 24, 1995 and transferred to the cardiology department on August 1. He was discharged on August 22 after being granted bail Wasulal Narayan Lakhi was admitted in the department of orthopaedics on April 11, 1994. He was then transferred to the department of cardiology on June 2. He was discharged against medical advice after being granted bail. Kapil Dev Singh, booked by the Bhandup police, was certified by Dr. Lekha Pathak, Professor and Head, Department of Cardiology, as suffering from ischaemic heart disease. The court asked Dr. Anil Kumar in the same department to opine. Dr. Kumar submitted that Singh was not suffering from the ailment. (Some more cases are also referred to in the report.)

Senior professors attached to JJ Group of Hospitals remarked that unless there was a nexus between a section of doctors and criminals such criminals could never have been admitted without valid reasons. In several cases it was confirmed that patients developed 'convenient illness' to avoid arrest.

The inquiry ordered by the Maharashtra Medical Council (MMC) into the nexus between doctors and criminals has not made any progress. When the MMC asked the Dean of the JJ Group of Hospitals to submit the case papers to the Council, the Dean sought the permission of the DMER. The DMER, ex-officio member of the MMC, was expected to attend the meeting with the relevant papers. He failed to make an appearance.

Doctors abetting artful dodgers (continued) [4]

The Chief Metropolitan Magistrate of Delhi rejected the report of the doctor in Tihar Jail Hospital about the illness of the self-styled godman Chandraswami and ordered constitution of a medical board to examine him. Magistrate Prem Kumar described the report submitted by the medical officer in the jail as a 'procured' report. Passing a severe stricture against the medical officer, Mr. Kumar said, "On careful perusal of the report it seems that this may be a case of 'fixing' the jail doctor and thereby securing or procuring from him the desired medical report to make medical unfitness a ground for the prisoner not to attend the court and thus obstruct the progress of a smooth trial. The doctor has given quite a vague report and the diagnosis has not been clearly mentioned. It did not mention the perusal of any old record of the disease or any new investigations."

Doctors abetting artful dodgers (continued)'

Rejecting the medical report by the Tihar Jail medical officer, [illegible] Magistrate Prem Kumar said, 'It seems like a made-up report, for obvious reasons.' He refused to believe defence lawyer Ashok Arora's contention that Chandraswami was not getting any attention in jail and that he was informed twice about his being in a state of coma. Mr. Prem Kumar expressed surprise on the medical officer's conclusion on the basis of plain X-rays that Chandraswami was likely to suffer irreparable damage to his nerves and pointed out that there was no expert opinion such as from an orthopaedic surgeon nor was a test such as computerised tomographic scan or magnetic resonance scan carried out.

(Since the publication of this report, the Chief Metropolitan Magistrate obtained the opinion of experts at the All India Institute of Medical Sciences, who disagreed with the medical officer at Tihar Jail. The latter has now been asked to justify his stand, especially in the light of the expert opinion.)

Physician-assisted suicide - some tormenting questions[6]

In an early response to the lifting of bans on physician-assisted suicide by two federal appeals courts in USA, the New York *Times* posed a question that torments doctors: 'Will the right to die become the duty to die?'

Is it likely that pressure will now be brought on the sick and disabled - self-imposed or from relatives -into choosing suicide over prolonged, futile and expensive therapy. Doctors, poorly trained in the treatment of pain and pressed by managed-care companies eager to cut costs, may put implicit pressure on their patients to choose suicide by not offering them acceptable alternatives.

Since existing law confers upon surrogates the right to withhold life support from mentally incompetent patients, will it also allow surrogates to decide that a terminally ill patient should be given a lethal drug?

Will the right to assisted suicide lead to euthanasia?

Maharashtra Medical Council [7]

I think it is useless to expect justice from the medical council. In medical councils, professional sympathy and professional contacts play an important role against the complainant in the case. No proper hearing takes place.

The council conducted the hearing of my case without reference to the medical records of the case. When I received an order from the medical council, I found that my statements had been altered to [illegible] doctors. The state-

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.

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FROM OTHER JOURNALS

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 pa-