improved skills but this should not be used as a excuse for brand promotion and for squeezing money from the poor.

Institutions like the Medical Council of India, the Indian Medical Association, the Indian Drug Manufacturers' Association, the Drug Controller of India and the judiciary should not only have suitable guidelines and laws but also monitor their application. They must have the power to enforce these rules. Unfortunately, they have neither nails to claw, nor teeth to bite, and not even a loud bark to warn.

Steps forward

The sky seems to be full of dark clouds but occasionally there is a silver lining. For example, some time around 1980, the general body of the Indian Academy of Paediatrics (IAP) took a donation for an oration made by an infant milk-substitute producer. In January 1997, the IAP resolved that "The IAP shall not accept the sponsorship in any form from any industry connected directly or indirectly with the products covered by the Infant Milk Substitutes, Feeding Bottles and Infant Food Act, 1992."

The current dependence of the medical profession on commercial sponsorship is a result of the failure of end-organ: the doctor. If doctors are convinced and committed to their ethical responsibility, they will not yield to the unscrupulous pressures of the industry. They must learn to say 'No' to gifts, subsidies and hospitality; to aid with strings attached; to brand promotion; and to prescribing irrational drugs and formulations.

Arun Phatak

Consultant paediatrician, editor of the Society for Rational Therapy and chairman for the Committee for the Protection of the Child Consumer of the Indian Academy of Paediatrics.

Based on the presentation made at the International Conference on Ethical Values in Health Care at Panchgani, January 2-4, 1998.

Neurosurgery and medical ethics

The Ninth Convention of Academia Eurasiana Neurochirurgica Houthem-St. Gerlach, The Netherlands July 29 - August 1, 1998.

The Academia Eurasiana Neurochirurgica was founded in 1985 by Professors H. W. Pia (Giessen, Germany) and Keiji Sano (Japan) to foster exchanges between European and Asian neurosurgeons. This year, the theme was medical ethics.

Oriental views on ethics

H. Handa (Japan) reviewed traditional ethical ideas on life and organ transplantation in Japan and explained the Japanese reluctance to embrace the concept of brain death. The belief that the soul resided in every part of the human body disallowed the removal and transplant of a body part. Why, then, do the Japanese accept transplants from live organ donors? "It is difficult to explain," said Dr. Handa. One senses that Japanese society is in the process of coming to terms with the concept. Dr. Tomasz Trojanowski (Poland) commented that Polish law presumes the donor's willingness; persons not willing to donate organs must register their objection on admission to hospital. While persmission for organ removal is sought from the families of brain-dead patients, the law does not require this consent.

Dr. Iftekhar Ali Raja (Pakistan) discussed Islam and medical ethics. Starting off with a quotation from Einstein ("Religion without science is lame; science without religion is blind."), among the issues Dr. Raja discussed was euthanasia. He quoted Prophet Mohammed's last address: all killing (except that prescribed by the courts as punishment for certain well-defined crimes) is prohibited. "There is no mercy in such killing," Dr Raja said.

Dr Sunil K Pandya, *Flat 11, fifth floor, Shanti Kutir, Marine Drive, Mumbai 400 020*

Dr Sunil Pandya (India) showed how the ancient Indian principles of medical ethics were at considerable variance with current realities. Dr. Fahlbusch (Germany) posed an ethical dilemma: what if a person dying ont the banks of the Ganges was found to have an eminently treatable illness like a blood clot? Would it be justified to enforce treatment on someone who had prepared to die and gain salvation?

Dr. A. Van Bommel, a convert to Islam who held the post of Imam, pointed out that the sanctity of life from the Muslim

Discussions on medical ethics often concentrate on dramatic issues such as euthanasia, neglecting the physician's positive duties: relieving pain, consoling and making the patient comfortable as the end approaches

perspective demands every effort at preserving life. The ventilator would not be switched off as long as the heart was still beating and was evidence of life. Dr. Harry Rappaport (Israel) said cessation of respiration is central to the Jewish diagnosis of death. The rabbinical criteria for death include cessation of respiration and the diagnosis of irreversible brainstem damage. The Jewish doctor may not shorten life in order to improve the quality of survival.

Dr. Graham Teasdale (Glasgow, Ireland) felt that the attempt to solve ethical dilemmas on the basis of traditional religious beliefs implied an excessive reliance on authority, and could be antithetical to a modern, scientific approach to ethics. An ideal distillate of traditional wisdom and modern concepts would be possible through cross-cultural dialogues .

Christian thought

The first session on Christian thought noted that physicians are expected to have compassion -- which different

from pity — for their patients. Since man has no right to interfere with life, the participant stated that euthanasia and assisted suicide were unacceptable. At the same time, the prolongation of useless life implied refusal to accept God's tenderness and mercy. Extraordinary means of preserving life which had lost all meaning were forbidden.

Professor W. J. Eijk (Netherlands) pointed out that discussions on medical ethics often concentrate on dramatic issues such as euthanasia. and neglect the physician's positive duties — relieving pain, consoling the individual and generally making the patient comfortable as the end approaches.

Dr. E. O. Backlund highlighted some anomalous situations following from current definitions of brain death: dead and living patients are treated side by side whilst formalities for organ donation are completed; the physician diagnosing brain death chooses the time of the patient's death — which can have judicial consequences; a baby can be born after the death of its mother.

On death with dignity, Dr. M. Nagai (Japan) felt that all acts that bring the patient closer to natural death are justified. The patient must be helped to die like a human being. Dr. Backlund commented on the perspective which views death as something to be fought tooth and nail. On the other hand, euthanasia is often taking the easy way out when counselling and good palliative care would have have been appropriate. Dr. Rappaport expressed doubts on the current trend in which life-and-death decisions are made by committees of hospital managers, lawyers and clergymen. While taking away doctors' powers to make decisions, will society absolve them of their responsibilities?

Dr. Graham Teasdale discussed ethics in research. An important argument made was that the insistence on fully informed consent can cause needless cruelty to patients and their relatives. Explanations of everything that can go wrong is not in the interests of the patient's peace of mind.

Dr. R. Dillman, Secretary of Medical Affairs, Royal Dutch Medical Association, presented details on the Netherlands experience with euthanasia. Doctors had been divided on the public demand for euthanasia. It was permitted after a national debate, and under specific conditions, to ensure transparency and accountablity. The law does not permit euthanasia, but no legal action is taken if the conditions are followed. Six thousand of 9,000 requests for euthanasia were turned down because the suffering was not unbearable, it could be palliated, available treatment had not been completed or there was evidence of treatable depression. The Netherlands Parliament will now consider legal modifications to make euthanasia legal.

The lessons from the Dutch experience: an euthanasia programme should not be embarked upon without an adequate legal framework that ensures transparency and accountability; patients must have free access to high quality medical care before such a step can be considered; there must be a full professional review of each case, and euthanasia is not an alternative to palliative care but is possibility when all else has failed to afford relief.

Dr. E. Schroten (Netherlands) discussed professional integrity in teaching medical ethics. The subject was best introduced with case studies, not ethical theories, with a phased analysis consisting of questions such as: What is the moral question? What are the options at first sight? What other information must be obtained? Who must be involved? What are relevant arguments?

The meeting was unusual in that it focussed on ethics in neurosurgery from a variety of viewpoints and contrasted traditional, religious and historical concepts with those based on modern scientific thought.

Sunil K. Pandya

Hardships of medical teachers

INCREASING pressures on medical teachers
Often talked and addressed among themselves
Due to limitations in their work
Patient care, teaching, administrative and research works

Impedence of their abilities and work
Though asking for expansion and new ones
Finally adjust with available ones
Due to financial constraints

Incresasing workload every day
Lead to frustration and despondency
Representations are made on every other day
Hoping for improvement, on one of these days

Examinership,considered as prestigious
Some get it always,
Others get it at times
Needs influence and pulls

Internal examinership gets recognition
Also avoids leave and dislocation
But subjects one to local pressures
And to satisfy many people

External examinership too has difficulties
Tedious travel experiences
Followed by reimbursement policies
When money comes, subject to I.T. returns

More responsibilities including legal works
The threat of transfer— for service persons
And out-of-turn promotion — the hanging swords
Also no vacation as in for other teachers

P Thirumalaikolundasubramanian
Gizan, Saudi Arabia