

Reflections on dying

Reflections on *Freedom to choose · Dying with dignity · Voluntary euthanasia* Dr. B. N. Colabawalla
Mumbai: Society For The Right To Die With Dignity. 2001. 40 pages. Paperback. Rs. 40.00.

(Copies may be obtained from Dr. Colabawalla at A-3, Ben Nevis, Bhulabhai Desai Road, Mumbai 400026.)

Dr. Colabawalla is an urological surgeon of distinction who retired as a professor at the Grant Medical College and St. George Hospital, Mumbai. He later set up the department of urological surgery at the Jaslok Hospital and Research Centre. As part of his second career, he serves the Society For The Right To Die With Dignity and is currently its Chairperson.

He has dedicated this slim book to Mr. Minoos Masani. The late Mr. Masani's many qualities of the mind and heart are well known to many and the dedication reflects Dr. Colabawalla's admiration for him. As with Mr. Masani, so with Dr. Colabawalla – the spade is a spade and not an implement meant to turn the earth over.

The inside cover of the book provides an all-too-brief glimpse of some of the facets of Dr. Colabawalla's life and work.

The prefatory note outlines the scope of the book and states the reason for addressing the Indian audience differently from those in the West.

Eight sections follow, ranging from perspectives on living and dying to Dr. Colabawalla's personal epilogue. These sections take the reader by the arm, gently but firmly, steering clear of ambiguity and lack of reason. The joy of living is emphasised, as is the inevitability of death. A distinction is made between measures taken to save life and those that merely prolong death. The tragic aspects of modern medical high technology have been highlighted.

Dr. Colabawalla provides the reader an understanding of his own reasoning and traces logically the means by which he has reached his own decisions on dying with dignity, the freedom to choose how he would like to die and when it may be necessary for the medical profession or others to help a person die.

There is no attempt at skirting delicate issues. Matters of philosophy and religion are treated with dignity and discussed without passion. The generation of light, not heat has been the motive in the production of this volume. I commend it. It will help you come to terms with issues not commonly discussed. It may help you overcome prejudice and open your mind to further thought.

The interested reader may wish to obtain a copy of the eight-page booklet describing the need for us to write a living will. It provides a model will, which can be modified by the individual reader. It is available from the address noted above.

Sunil Pandya

Trade and our health

■ This editorial notes that while developing countries' negotiations with the World Trade Organization on trade related aspects of intellectual property rights will be important for their access to essential drugs for life threatening diseases, the WTO's agreements also affect national policies on a range of other health-related issues.

“Some of the proposals under negotiation regarding GATT indicate that developing countries will be asked to open up health service markets to foreign competition... experience in middle income countries indicates that foreign competition in health service markets tends to worsen equity in financing and reduce access to care for the poor.”

Health care will be affected even without a liberalisation of trade in health services, as the WTO discusses other services such as health insurance. As the US and the European Union demand access to the insurance market in countries like India, the experience of private insurance in Latin America teaches a lesson on how these companies operate, selecting the healthiest people and dumping high-cost patients on to the public sector.

“After trade related aspects of intellectual property rights and access to drugs, the next major health issue on the agenda of the World Trade Organization may well arise in the course of negotiations on trade in services. Health professionals need to work with trade officials to minimise the risks to health equity from liberalisation of services trade, and ensure that any resulting economic gains in health related service sectors generate tangible public health benefits.

Lipson Debra J. The World Trade Organization's health agenda Opening up the health services markets may worsen health equity for the poor. Editorial. *BMJ* 2001;323:1139-1140.

In favour of sex selection

■ In recent months, a series of articles have appeared in ethics journals in the West, discussing the ethics of sex selection. These essays are particularly important for those following current developments in India on sex selective abortion and other sex selection techniques. David McCarthy argues that that medically assisted sex selection for non-medical reasons ought to be legal: it cannot do harm to individual children, there is no evidence that it is affecting the sex ratio of western societies. Sex selection is one form of reproductive autonomy, giving parents the right to choose the child of a particular sex.

McCarthy David. Why sex selection should be legal *J Med Ethics* 2001; 27:302-307.

It's immoral but not necessarily illegal

■ J M Johnston examines the law and practice on sex selective abortion in New Zealand, and also examines the various arguments for and against the practice.

Johnston suggests that even if sex selective abortion is not based on son preference – with its social consequences – its is morally wrong because it encourages discrimination based on sex. “...sex is not a morally appropriate differentiating factor and allowing sex selective abortions will mean allowing abortions for trivial and unjustifiably discriminatory reasons, thus undermining the serious and strong reasons most women have for seeking the procedure.” Interestingly, Johnston concludes that while it is immoral, sex selective abortion must be tolerated wherever abortion is available on demand.

Johnston JM. Are sex-selective abortions wrong? *New Zealand Bioethics Journal*. 2001 February: 9-16.

Does appealing to ethics work?

■ This collection of three essays discusses pharmaceutical companies’ responsibilities to provide drugs in poor countries at an affordable price. David Resnick acknowledges the companies’ responsibilities but argues that they are not absolute. They “may be balanced against other obligations and commitments”. A company may also look at the business environment and the scope for a profit. Developing country governments must respect international trade agreements, and can work in cooperation with industry (rather than confront it) to encourage it to act responsibly. Dan W Brock challenges the arguments made by Resnick that companies have a social responsibility. Separately, he suggests that even if such a social responsibility were acknowledged, this would not go far towards meeting the drug needs of the developing world, given that pharmaceutical companies’ first responsibility is to their stock-holders. The vast income inequalities between rich and poor countries will force the latter to ignore patents if they are to provide their people with essential drugs. In other words, poor countries would do better if they confronted pharmaceutical companies, instead of appealed to their social responsibilities. Norman Daniels also questions Resnick’s appeal to social responsibilities, proposing instead that the solution is to regulate pharmaceutical companies, both internationally and domestically.

Resnick D. Developing drugs for the developing world: an economic, legal, moral and political dilemma. *Developing World Bioethics* 2001; 1: 11-32. Brock Dan W. Some questions about the moral responsibilities of drug companies in developing countries. *Developing World Bioethics* 2001; 1: 33-37. Daniels Norman. Social responsibility and global pharmaceutical companies. *Developing World Bioethics* 2001; 1: 38-41.

Why dangerous drugs are not banned

■ When a very profitable drug is banned abroad for its adverse effects, interest groups in India resist similar action here. This editorial illustrates the point with reference to the drug cisapride. It refers to a report in the *Indian Drug Review* on a meeting questioning the value of a ban on cisapride in India. The meeting argued that the drug is cheap and cardiac adverse affects due to its use have not

been reported in this country – even while admitting that we have no system of adverse drug reporting. “What the ‘meeting of the minds’ wants is simply this: Cisapride has a market. The manufacturers cannot simply sacrifice it for the safety of the consumers. So ‘an Indian system of adverse drug reactions should be evolved’. This may take years or even decades. The manufacturers will have ample time to make their profits, never mind what happens to the hapless consumers.”

Editorial. Why not engage others to homework while we go on eating the pie and killing people? *BODHI* 2000; 37: 129.

Eugenic abortion

This writer re-examines the moral status of abortion in the context of current genetic research which is likely to lead to a growth prenatal genetic testing. He concludes that “secular philosophy should ultimately admit that the moral status of the fetus is uncertain, and this uncertainty itself makes abortion morally problematic. While this does not imply that abortion is always morally wrong or that it should be legally prohibited, it does recommend a [moral] presumption in favor of preserving fetal life except in special circumstances. A relevant worry is that the rise of eugenic abortion gives new force to slippery slope arguments that we will be led down a path to a situation where more fetuses are terminated for relatively trivial reasons and that this will promote other bad social consequences. This might justify legislative discouragement of certain genetic interventions.”

Selgelid Michael J. Eugenic abortion, moral uncertainty and social consequences. *Monash Bioethics Review* 2001; 20: 26-42.

Genetic counselling

In a society where women get blamed for infertility, for the sex of the child, or for any disability, medical professionals must be thoughtful while disclosing genetic disorders to the family. Women have faced discrimination from their husbands and in-laws because of a genetic disorder in their children. The writers discuss three cases which lead them to reassess the use of genetic counseling in India, particularly in relation to the policy of disclosure of women’s carrier status. They suggest that the problem will become more serious with the growth of genetic centres in the country, and the shortage of professionally trained genetics counselors. Information provided during genetic counseling should not lead the woman to feel guilty, or the family members to blame her. The authors call for the development of ethical guidelines for genetic counseling, which are appropriate for the Indian situation.

Phadke Shubha R, Agarwal SS. Adverse effects of genetic counseling on women carriers of disease: the Indian perspective. *Natl Med J India* 2001; 47-49.