FROM OTHER JOURNALS

Preventive medicine - not an unmixed blessing[1]

The estimate by some experts that modern medicine can forestall 70 percent of all illnesses led law-makers to push for the inclusion of preventive medical services in insurance benefits packages. They reasoned that if fewer people got sick, fewer would require medical care with greater health for less money.

In fact, a burgeoning collection of studies shows that disease prevention is rarely a steal. Of all preventive services analysed recently only three paid for themselves: prenatal care for poor women, tests in newborns for congenital disorders and childhood immunisations.

Preventing disease is often more expensive than treating it. Screening for cancer, especially cancer of the prostate, costs more than does therapy. The current stew over testing for cholesterol and attempting to prevent atherosclerosis is another example. The benefits from prenatal care too can be logically questioned. (See box on page 126 of this paper.)

Faith T. Fitzgerald of the University of California at Davis made another point: ‘Even if we were to be successful with the prevention of all diseases, we would bear a population of older people undergoing biological decay, who could live longer and cost more while they were dying.’ Of course, the fact that all of us will eventually die is no reason to sidestep pain and suffering whenever possible, whatever the price but when nations lack resources to provide care for its sick and dying, can policymakers take gambles on ‘preventive care’ whose effectiveness does not justify the costs?

As a Rand study expert put it, ‘We already ration care in this country (USA) on the basis of access, insurance and knowledge. I’d rather try to do it on the basis of scientific evidence.’

Informed consent[2]

There appears to be general agreement that it is necessary to obtain the patient’s consent to a course of action decided upon by the doctor. **Veatch,** Director of Medical Ethics at the Kennedy Institute of Ethics, Georgetown University, Washington, asks whether we ought not to go further. If we agree that in most cases the clinician makes guesses, informed and expert though they may be, at what is in the overall best interest of the patient should we not be offering the patient all plausible options, the clinician recommending one of them? By doing so we shall render unto the patient a greater degree of the autonomy that is her right.

The decision will now be based on the patient’s beliefs and values rather than those of the physician. Whilst the clinician is able to judge what will serve the patient’s medical or health needs, he is often unable to determine what is in the best interest of the patient’s other interests, including moral goals or her deep personal relationships. Factors such as the physician’s obligations to individuals and groups other than the patient will now be bypassed.

‘To put it bluntly, the only way to know whether an intervention is good medicine is to ask the patient.’

The evolution of modernity[3]

Taylor, Professor of Political Science and Philosophy at McGill University, Montreal sees western modernity as the growth of reason fostered by all cultures and discusses the various modes for such growth.

Two schools of thought are considered. The ‘acultural’ postulates loss of false and harmful myths and a novel form of moral self-understanding. The emphasis here is on shedding of beliefs and ways that can no longer be justified, leaving us with residual facts on which we base our outlook.

The second school, supported by Taylor, invokes the original spiritual vision - ‘a constellation of understandings of person, nature, society and the good’ - as the key to modern thought, belief and the advancement of a ‘public sphere’ of open debate and exchange. All cultures, put through rational and social changes, will converge on that form of life termed modernity. There is ‘a movement from one constellation of background understandings to another, which repositions the self in relation to others and the good.’

On death and dying: should the doctor tell?

‘Sherwin Nuland (surgeon) tells us that there are shared. myths between doctors and patients about how we die.’ The patient may continue to hope about cure right **upto** death. Physicians may provide the basis for such hope. Most of us expect to die with dignity.

Nuland warns against using medical technology ‘to achieve a triumph of temporising’ over inevitable death. Modern death in hospital, away from loved ones, provokes unarticulated fear and loneliness. He asks physicians to share the limitations of their art and science with patients. Nuland misled his own brother, dying of cancer of the colon, because he believed that ‘telling my brother the absolute truth would take away his only hope’. The lesson learnt? ‘Of the many ways to die alone, the most comfortless and solitary must surely take place when knowledge of death’s certainty is withheld.’

Fins warmly commends this thoughtful and challenging book.

Medical hustlers’

Das’ essay brings to mind Arthur Koestler’s book *The Call Girls (1973).* He describes scientists who ‘travel round the clock from the pole to the equator in pursuit of meetings and seminars with an international flavour’. He rightly decries the current trend to organise symposia in posh hotels. ‘An exceedingly sumptuous meal is preceded by beverages of different strength and hue. Imbibing them leads to much Bacchanalian mirth being merged with lack of intellectual worth. The fact that there is evidence of appalling poverty in the very backyard of a hotel of opulence has no impact.. .’

The contrast between them and Einstein is made obvious. Einstein described these social events as feeding time at the zoo. On such occasions he ‘retired to the back of my mind, where I am happy.’ Whilst Einstein had no ill word for others, our seminar-conscious experts are conspicuous in running down others with subtle nuances to emphasise how good they are by comparison.

‘Finally, there is the art of plagiarism.. . In its simplest form it is an attempt to get on in life at the cost of abandoning... ethical values.’

Das sums up with a quote from Katha-Upanisad (I,ii,5):

‘Living in the midst of ignorance and considering themselves intelligent and enlightened, these senseless people go round and round, following crooked courses, just like the blind led by the blind.’

Palliative care[6]

Margaret Otlowski, senior lecturer in law at the University of Tasmania, discusses legal and ethical issues in the care of patients with advanced disease, beyond cure. Such care is demanding and strenuous. Of paramount importance is relieving symptoms - pain, nausea, insomnia, anxiety and depression.

She refers to the distinction between killing such patients and letting them die, the former being prohibited by law. Another division causing concern is that between ordinary means of medical care (which must be used) and extraordinary means (which may be avoided).

The decision to shift from curative treatment to palliation, itself, can only be made with the consent of the patient and family. Not everyone agrees with the British lawyer who argued that once it is certain that curative therapy proves a burden to the patient with no hope of success, it is unethical to persist with it.

Drugs intended to relieve pain may have to be given in doses that might prove harmful. Provided the doctor’s primary intent is to afford relief from pain, the administration of a dose that might prove fatal is not frowned upon by British law.

Otlowski also discusses DNR (Do Not Resuscitate) orders and the withholding of nutrition and fluids. Our natural reluctance to starve an individual to death notwithstanding, the provision of nutrients and fluids through artificial means in the face of an advance directive against it from the patient may be unethical.

The essay also deals with decision-making by competent patients and that for incompetent persons. The final section asks whether doctors can actively help a patient who requests death. Dr. Jack Kevorkian’s acts (also discussed on page 5 of this journal) appear to be gaining support from American society and the medical profession in that country.

This thought-provoking essay asks society to consider whether, under exceptional circumstances, it is right for a doctor to assist a competent patient to die and, indeed, actively induce death. If there is general agreement, the law must be amended. (On pages l-2 of this journal, Dr. Kuhse provides a note on recent legislation in Oregon, U. S. A. making medically assisted suicide legal.)

Ethics in bedside medicine[7]

Kerridge and Mitchell are lecturers on health law and ethics in the University of Newcastle,’ Australia. They discuss everyday ethical problems using four case studies - a Jehovah’s witness who refuses a blood transfusion; a drug abuser with suspected bacterial endocarditis who refuses admission; a patient who, when promised confidentiality, talks of his plans to assault a nurse and a patient with extensive cancer whose relatives insist that he not be told about it.

To arrive at ethical decisions, they suggest the following steps: i) get the facts ii) identify ethical issues iii) determine ethical principles that are relevant iv) resolve ethical conflicts v) justify clearly stated clinical decision vi) ensure that it is within the legal framework.

Advance directive[8]

As the term suggests, medical attendants can be directed, in advance, on the course to be followed should an individual become mentally incompetent to participate in making decisions at any stage in the future. Robertson, a consultant anesthetist in Aberdeen, proposes a standard model document for this purpose. He provides a draft document (on page 59 of his paper), lists background conditions such as dementia, persistent vegetative state or irreversible coma, terminal disease (cancer or debilitating neurological ailments) and defines some possible conditions that could trigger an advance directive: cardiac and/or respiratory failure, acute renal failure, major gastrointestinal bleed, major cerebral stroke and a serious accident.

Practical matters are emphasised. Close relatives and friends must be informed by the person making such a directive. The directive should be witnessed by two persons able to certify soundness of mind. The original document should be retained in the individual’s personal papers, copies being placed in medical case records and with the legal advisor. The person facing loss of capacity should nominate a trusted person to express his or her views later.

Medical fallibility’

Whilst discussing legal aspects of the definition of ‘medical futility’, Capron provides yet another example of how doctors can make serious errors of judgement.

Baby Ryan Nguyen (pronounced Win) was born six weeks before his due date. He was asphyxiated. Heart sounds could barely be recognised. His physicians at an American hospital diagnosed severe brain damage, intestinal obstruction and renal failure. They concluded that he was almost certain to die even if he was kept on dialysis for two years and then given a kidney transplant. Specialists at a renal unit were unwilling to treat Ryan as ‘long-term dialysis would not only be inappropriate but would be immoral’ since it would prolong agony with ‘no likelihood of a good outcome’.

The parents did not accept this verdict and obtained an emergency order from a Court directing the hospital to ‘take whatever immediate steps (are) necessary to stabilise and maintain the life of Ryan Nguyen, including dialysis of the kidney functions’.

In the event, once his intestinal obstruction was treated by surgery, he did not require dialysis. Despite the seizures early in life and the CAT scan findings interpreted as showing irreversible brain injury, Ryan seems free of any permanent neurological deficit. He shows development appropriate to his age.

Medical students and ethics”

Dr. John Conley, an ENT surgeon, pledged an award of US$5,000 to the medical student/s writing outstanding essays on medical ethics. Students were asked to write on ‘How can medical students best develop ethical thinking and behaviour?‘. A hundred responses followed. Two of the four prize-winning essays are reproduced.

John O’Toole of the Harvard Medical School, advocating the use of the narrative, pointed out that the greatest challenge facing medical students is that of remaining humane. Bemoaning the disconnection between emotive and empathic aspects of ‘doctoring’, he pleaded for the use of narrative to reinforce and supplement abstract ethical theorising. The connection between medicine and literature should be exploited towards this goal. Stories fleshing out the intricacies of the complex relationship between doctor and patient will nurture moral imagination and help understand meanings and moral issues hidden in the voices of patients.

Narratives enrich all aspects of medical education. 'How much more powerful and salient would those anatomical lessons be if students knew the personal stories of their respective cadavers.'

Roxanne Sukol of the Case Western Reserve University School of Medicine outlined the moral signposts guiding her own actions:

i) Speak truthfully ii) Treat patients with respect iii) Acknowledge your own humanity iv) Keep the goals of our art constantly in sight. She quotes Kass: 'For if healing the sick is always the heart of the physician's business, and, if, as I suspect, the essential features of the healing relation between the physician and the ill have not been, indeed cannot be, altered by technological advance or societal change, medicine must remain at its core... a very special profession...'

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ANNOUNCEMENTS AND NEWS

Courses *in bioethics: University of Otago*

The Bioethics Research Centre at the University of Otago was established in 1988 in response to growing awareness of new ethical issues related to law, medicine and technology; issues which touch upon the lives of everyone. It is the only centre for applied ethics in New Zealand.

The Centre has developed a network of links with other research centres and is attracting an increasing number of overseas scholars. Its staff offer supervision for postgraduate masters and doctoral degrees. The interdisciplinary nature of the staff ensures interaction with experts from a variety of academic disciplines.

The courses offered can be used to obtain the following degrees in bioethics: Master of Health Sciences, Master of Bioethics and Health Law (combining course work and thesis) and Master of Medical Science (for medical graduates). Further information can be obtained from Professor Alastair V. Campbell, Director, Bioethics Research Centre, P. 0. Box 913, Dunedin, New Zealand.

Courses in Bioethics: Monash University

The Centre for Human Bioethics, Monash University (Clayton, Victoria, 3 168 Australia) offers a postgraduate degree in Bioethics. The Master's degree can be obtained by course work and minor thesis or by a major thesis. Compulsory subjects include ethics and legal issues in bioethics. Elective units include questions on life and death, ethical issues in patient care, reproduction and genetics. Applications can be sent to Dr. Helga Kuhse, Director at the above address.

Courses in Bioethics: Southern Illinois University

The Department of Medical Humanities, Southern Illinois University School of Medicine, P. 0. Box 19230, Springfield, Illinois 62794-9230 (Director: Dr. George J. Agich) offers several integrated teaching modules and medical humanity modules. The latter include philosophical and ethical aspects of physician-patient relationship, organ donation, physician-assisted suicide, health care rights and obligations and conflicts of interest. Dr. Agich also runs the International Network for Bioethics Education.

Voluntary Health Association of India (VHAZ)

VHAI, a non-profit society, completes the 25th year of its laudable activities. It links over 3,000 health and development organisations spread across India and promotes community health, social justice and human rights in the provision of services related to health. It has evolved several low-cost programs harmonising traditional skills with modern knowledge. It runs two centres of traditional systems of medicine in Uttar Pradesh and Karnataka. Its publications include *State of India's Health* (August 1992), *Health expenditures in India* and periodicals including a bi-monthly journal and newsletters. *Co-traveller,* its quarterly newsletter, features essays discussing neglect of patients by doctors making it necessary for us to issue the warning 'Caveat consumer' in medicine as well (1995;6:5-6) and on stemming the kidney bazaar (1995;6:7-8). In the first essay, the author asks the medical profession: 'In the process of progress where have you lost the human face?' Telling cartoons illustrate these essays. *Health related cases under consumer law* (1995, 40 pages) discusses the Consumer Protection Act of 1986 and pleads for 'medical services as if consumers mattered'. Also covered are the rights of the patient, means open to the patient and relatives for availing of these rights and case stories from hearings at the National and State Commissions where patients were able to obtain just settlements.

Ethics and Intellectual Disability

The Network on Ethics and Intellectual Disabilities has just published Volume 1, number 1 of *Ethics and intellectual disability.* The newsletter will facilitate interaction among those working in this field. The first issue features Dr. J. A. Costa e Silva's essay entitled 'Multicultural ethics and intellectual disability', describing the need for the network in this field, efforts being made by WHO and how multi-faceted collaboration will help remove the stigma attached to mental retardation. In the section entitled 'The law and retardation', the case Ricci v. Olkin is summarised. The court order in the class action