FROM OTHER JOURNALS

Euthanasia in Australia [1]

Kuhse's editorial reviews the legal aspects of euthanasia in Australia. Kuhsc points out the deep divisions on this issue on moral and philosophical grounds in Australian society. The Prime Minister, John Howard and the Leader of the Opposition, Kim Beazley were publicly seen to oppose the practice.

Kuhse narrates the case of Mr. Rod Dent to show how political pressure can alter even a deeply felt, personal decision. Rod Dent had publicly supported his father's decision to end his life. Later, there was a *volte face.* Rod Dent told a journalist, in an interview recorded on tape, that he had come under intense pressure from Kevin Andrews, the Finance Minister and others and felt it was in his own interest as a senior political strategist that he fall in line.

'In a liberal and democratic society, such as Australia, voluntary euthanasia must, ultimately, be a matter of personal liberty,' says Kuhse. She counters the common objection based on the slippery slope hypothesis by pointing out that even under existing, prohibitive laws, doctors are actively engaged in the practice of voluntary euthanasia and assisted suicide - well documented in large numbers of empirical surveys in Australia and overseas. Doctors are intentionally ending the lives of patients, virtually unregulated, either through the administration or prescription of drugs, or by bringing about the desired result by some other means that disguised intent. (This essay was written before the Australian Senate passed the anti-euthanasia bill. The section entitled News in *brief* - pages 5-8 - also contains important information on this subject.)

Xenotransplants in Britain and the US [2]

A committee advising the British government has recommended that transplants of animal organs into humans should be prohibited until the risks are better understood. The Department of Health's Advisory Group on the Ethics of Xenotransplantation calls for new laws governing the field. The report recommends setting up an independent committee to monitor the progress of xenotransplantation and approve experiments. The recommendation has since been accepted by the government. According to the Advisory Group, chaired by Professor Ian Kennedy from King's College, London, xenotransplantation is still too risky even to try experimentally.

A few months earlier, new guidelines on xenotransplantation had been released in the US. The guidelines, developed jointly by the US Food and Drug Administration, the National Institutes of Health and the Centers for Disease Control covers transplants of animal cells, organs and tissues into human patients. American hospitals that transplant organs from animals to humans might now need to add a battery of experts (specialists in infectious diseases, a clinical microbiologist and a veterinarian) to their research teams. They would also need to seek government approval for each operation.

Confidentiality [3]

Edmund Pellegrino, Director, Georgetown Center for the Advanced Study of Ethics, discusses in detail the issue of confidentiality, using the case of Anne Sexton as an example. The poet, Anne Sexton, committed suicide. Three hundred tapes of her sessions with her psychiatrist were released to Sexton's biographer with the concurrence of Sexton's daughter and literary executor. Publication of the book, containing accounts of Sexton's sexual aberrations, alcohol and drug abuse and accounts of emotional turmoil, stirred up strong criticism.

Pellegrino points out that the moral right to the protection of secrets is rooted in the trust essential to interpersonal relations. Without this we would lose the benefits of intimacy, counselling and advice on matters of personal interest and would be rendered vulnerable to harm from broadcast of information. Violations of confidence are violations of our person as our innermost thoughts, personal experiences, promises, foibles or vices are parts of our person.

Disclosure of confidence may be voluntary or involuntary. When voluntary, the patient releases the physician from secrecy by giving morally valid consent, obtained after informing the patient of the uses to which the confidential information is to be put. Involuntary disclosure must always be for the benefit of the patient (suicidal tendency) or prevention of harm to others (homicidal tendency). On the issue of infection by HIV, Pellegrino states, 'There is no justification to conceal knowledge of the possibility of exposure to a uniformly fatal disease like AIDS... if harm to an identifiable other person is a possibility.'

On the release of Anne Sexton's tapes, Pellegrino argues that this was unethical. To the argument that since Sexton is dead, release of the tapes could not do any harm to her, he points to the real harm that can be done to the memory of a dead person. He quotes Confucius: 'If we treat the dead as if they were wholly dead, it shows want of affection; if we treat them as wholly alive, it shows want of sense.'

Fittingly, he quotes Anne Sexton (in ***Doctors)*** to sensitise us to the complex nature of the doctor-patient relationship:

'The doctors should fear arrogance more than cardiac arrest.
If they are too proud,
and some are,
then they leave home on horseback.
But God returns them on foot.'

Awareness during general anaesthesia [4]

'Imaagine being in surgery when the surgeon believes you are fully anaesthetised. In reality, however, you are completely aware and alert. Your mind is racing. You fear that since you can hear the surgeon's conversation and feel his fingers on your body, no doubt you will feel the incision as well. in addition, you feel you are suffocating because the respirator does not let you breathe as much as air as you want... You then hear the surgeon ask for the scalpel. You try to beg and scream for him to stop but no sound comes out of your mouth. The surgeon finally makes the incision and you feel like you are going to explode. The pain is inconceivable. You want to die rather than continue with the operation. You feel violated and deceived...'

Grinblat lists the causes of patient awareness:

i) faulty anaesthetic technique - inadequate use of intravenous or volatile agents

ii) failure to check anaesthesia equipment

iii) genuine equipment failure

iv) 'under-anaesthesia' justified by patient's poor clinical state

v) failure of detection of awareness - monitoring of blood pressure, pulse, heart rate, sweating, lacrimation

The essay deals with all the legal aspects of this form of misadventure and how the patient may seek judicial compensation.

Fake admissions in Uttar Pradesh medical college [5]

The country's biggest fraud in medical admissions came to light at the Maharani Laxmibai Medical College and Hospital, Jhansi. The present principal, Professor V. K. Kulshreshtha, on instructions from higher authorities, ordered the cancellation of admissions of forty-four students who had gained entry to the course leading to M.B.B.S. in August 1995 using fraudulent means. These students were admitted to the medical college when Professor V. N. Prasad was Principal and Dean. The ousted students were to appear for the first professional examination conducted by the

Bundelkhand University, Jhansi.

Several lakhs of rupees had allegedly been collected from each candidate before admission. The students were then provided fake letters and University documents supposedly issued by the Director-General of Medical Education and Training, Lucknow demonstrating success at entrance examinations. Students also produced false mark sheets which showed much higher percentages than those actually obtained. All these students belonged to rich families and were from Lucknow or Kanpur.

As soon as this news broke, these students disappeared from their hostels and have, since, been absconding.

Chennai statement on bioethics [6]

Recommendations made at the conference on bioethics in Madras (16-19 January 1997 - organised by Drs. Darryl Macer, Frank Leavitt and Jayapaul Azariah), included the following:

- Bioethics includes the study of environmental, ethical, legal and social issues raised by applications of biology, medicine and science. Wide interdisciplinary debate is to be encouraged.
- Bioethics should be taught at all educational institutions starting from the primary level.
- Hospital ethics committees will have four functions: to provide education on ethics within the hospital; to facilitate communication between all persons involved in the care and treatment process; to be available for consultation on difftcult cases; to provide policy recommendations to the hospital.

Why do health professionals not speak out?'

Jim Welsh, medical director of Amnesty International, spoke of the barriers stopping health professionals from speaking out. He referred to the culture of fear of the gun, economic pressures including the fear of demotion or losing one's job and the manner in which the state can and does ignore medical evidence. He also referred to the need for educating doctors on the methods to be used when examining a victim of torture. He emphasised that disobeying corrupt and evil governments requires solidarity within the health care professions and support from other groups concerned about human rights.

He suggested four approaches:

1. Make it difftcult for governments to subvert medicine through concerted, collective action.
2. Strengthen the role of ethics in medicine and medical education.
3. Support basic rights.
4. Offer the strongest support to those at risk in the front line.

Removing the wrong organ at surgery [8]

The Case Commentary in the current issue of *Otago Bioethics Report* is thought provoking. A 56 year old man with a solitary tumour nodule in the centre of the right lung was scheduled for removal of that lung. 'On the day of the operation the surgeon arrived slightly late and somewhat flustered from a difficult operation at another hospital. (The patient) was already anaesthetised and positioned on the table, hidden under the drapes. The operation was uneventful... The following morning, routine post-operative X-ray was taken... To her horror (the surgeon) realised that the one remaining lung was the one with the tumour and that she had removed the wrong lung...' The question posed was: What should the surgeon do?

Both commentators (Nicola Peart, Senior Lecturer in Law and Professor John Morton of the Christchurch School of Clinical Medicine), emphasise that the surgeon must face up to her error. Dr. Morton also states that she must, at once, ensure that the patient's further physical and mental care receive very careful thought and attention. 'She must inform (him) what has happened and discuss with him (and his family) who will be responsible for continuing care. Under the circumstances, the patient may want his care taken over by another surgeon. She should make it clear to him and his family that this can be arranged...'

Bioethics on the Internet [9]

Readers able to surf might like to look up the following sites.

1. The Center for Bioethics. Ethics and Genetics at http://www.med.upenn.edu/%7Ebioethic/genetics.html
2. The National Reference Center for Bioethics Literature http://guweb.georgetown.edu/nrcbl/
3. *Hygeia* - an online journal for pregnancy and neonatal loss http://www.connic.com/~hygeia (Email: hygeia@connix.com)
4. The Kevorkian file: http://www.rights.org/deathnet/KevorkianFile.html
5. Series entitled 'Bioethics for clinicians' published in *Journal of the Canadian Medical Association:* http://www.cma.ca/e-pubs/bioethic.htm
6. The computer program used by patients who died under the Northern Territory Rights of the Terminally Ill Act: http://www.taunet.net.au/deliverance/
7. Gene map of the human genomc: http://www.ncbi.nlm.nih.gov/sciencе9/
8. For a very important cautionary tale (in more ways than one) see: http://www.web.co.za/arthur/cleanfaq.htm
9. An excellent bioethics list server: Biomed-L. To join it, send the following text in a message: SUB listserv@ndsuvm1.bitnet yourtirstname yourlastname

A philosophical view on euthanasia [10]

Killing is an act which is normally repulsive to man. When self-preservation demands that we kill, killing acquires a not entirely negative colour.

In euthanasia we need to answer two questions. Who is the agent for killing? Is euthanasia a killing or murder?

Mitra points out that switching off a respirator once a diagnosis of brain death has been made is not killing and is, thus, not euthanasia either. A terminally ill individual in severe pain which, in the opinion of doctors, will continue or even worsen till death, does not face a good death but what of the aged person afflicted by a variety of illnesses who refuses pills and potions and desires death? Physical pain apart, what if the patient suffers inexorable mental pain? Is letting someone die equivalent to killing him?

The strongest argument in support of euthanasia is mercy. Mitra suggests that if euthanasia be permitted in the case of physical pain, it must be extended to those in inexorable mental pain as well. In summary, he advises the clinician to place himself in the position of the patient before arriving at a decision - almost always a certain guide to proper care.

He also points to a danger: the request/consent of the patient may amount to nothing more than a formal rubber stamp to clear the conscience of the persons who will carry out euthanasia on the patient. There is a real hazard when non-suffering persons around the suffering patient effectively decide whether euthanasia is to be applied.

Organs for transplantation: demand vs supply [11]

Public awareness of the critical shortage of cadaveric human organs made available for transplantation in America was highlighted when baseball star Mickey Mantle needed a liver. This case also brought into prominence deficiences in the system used

to allocate these scarce organs.

The authors advocate the creation of 'organ markets' to set into motion a policy for the distribution of organs based on the powerful incentives provided by free market forces which will bring forth the additional supply of organs needed to met the growing demand for them.

They conclude that the cause of the shortage is the fact that many more organs are buried (or cremated) than the number of patients needing them. Add to this the sums needed to keep patients needing transplants alive till organs are available and the case for greater use of cadaver organs becomes compelling. The marginal improvement in results with living donors is rapidly declining as new immunosuppressive drugs are discovered. The case for subjecting a young, healthy individual to the risks of donating an organ such as a kidney becomes less and less defensible.

It is argued that the public policy that outlaws the sale of cadaveric organs only worsens an already difficult situation. 'The artificial shortage created by the zero-price policy pushes the value of the relatively few organs that are collected far above the market-clearing level.'

Attempts to obtain organs have included suggestions that preferences for donating organs for transplantations be sought when applying for a driver's licencc or submitting income-tax returns and these be recorded in such a way that they are obvious to attendants in hospitals when the person is admitted for medical care. Other attempts have included obtaining the consent of every patient on admission to hospital for removal of organs for transplantation in the unfortunate event of brain death being diagnosed.

Yet another proposed means is conscription. Every patient being admitted to hospital is informed that his organs will be removed for transplantation if brain death supervenes. 'This is anathema to most.

There appears to be growing enthusiasm towards offering compensation to donors and their families as an added inducement to donate organs. Some have proposed paying the funeral expenses. Others propose waivers of driving licence fees or incotne-tax rebates for those willing to sign binding agreements for donation of organs after brain death.

A few - such as the authors of this essay - go a step further. Why not organise organ markets? Under this system, agents of for-profit firms offer a market-dctcrmined price for either ante-mortem or post-mortem agreements for the firm to collect organs for resale to transplant centres. Since tangible rewards are involved, it is envisaged that this system will elicit a much more favourable response.

The authors list arguments for and against organ markets.

(We are indebted to Mr. J. B. D'Souza for access to this very interesting and thought-provoking essay. --Editor)

Scientific ethics in India[12]

Before independence, by and large, there was a scholarly commitment to the cause of science by a few dedicated scientists. The result was that India produced a Raman, a Saha, a Bosc and a few other outstanding scientists. After independence, the pursuit of science, in a very real sense, became one more job opportunity. It was not the idealistic desire to advance scientific knowledge that was the driving force, but solely the need to make a living. The desire of the government to establish quickly an educational, research and development base in the country, with faith in the ability of scientists to improve the standards of living of our people opened the gates for a rapid increase in investment by government in science.

The interface between science and technology, which could have attracted large direct investment in research and dcvelopmcnt, did not develop to any significant extent in India. Thus, while the number of persons pursuing a scientific profession continued to increase, real per capita investment decreased. The result has been a struggle within the scientific community for a share of the government funds.

The very nature of the scientific profession demands far higher ethical standards for its healthy growth. We have to note with regret that scientists arc no more virtuous that any other members of the community. The situation has not improved by the extreme importance given to the number of publications rather than their quality in deciding appointments and promotions. The driving force in science at present is not the pursuit of knowledge but the urge to survive. This has Icd to scientists compromising ethics in their professional conduct.

Integrity demands that a scientist is not honest only when others are looking at him but, more importantly, that he is honest and ethical when nobody is looking at him. The culture of the younger generation looking up to their seniors as models to emulate imposes enormous responsibility on them.

The responsibility for maintaining ethics lies on senior scientists in academic institutions. The heads of these institutions, instead of becoming protectors of scientific integrity, have become protectors of individuals who compromised it. When senior scientists get to know that something is wrong and do nothing about it, they provide a licence for others to emulate the wrongdoers. And so the disease spreads with an increase in adding their names to papers to which they have contributed nothing, plagiarism, falsification of data, creation of fictitious data...

If a Vice-Chancellor of a University lets off one of his faculty members with a mild censure when he violates the very core of the ethics of science in its practice by creating a false database or the head of an institute tries to project the image of rapid progress by including titles of papers resulting from research work done elsewhere by calling their authors 'honorary faculty' or an editor of a science journal delays publication of an issue so as to get one of his articles published in it, Indian science attracts contempt.

To argue that such rot exists in the developed world is not an answer. Academic and research institutions there arc active in curbing such practices. In any case, their malpractices arc their problems and certainly do not constitute examples for us to follow.

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