FROM OTHER JOURNALS

The Aruna Shanbaug judgment: 'next friend' the best friend?

In the context of the Supreme Court (SC) judgment in the Aruna Shanbaug case regarding passive euthanasia, this article looks at the judgment's implications for the right to autonomy and self determination of a person incompetent to consent. The writer argues that the judgment effectively denies this right, by giving priority to the views of the nursing staff of the hospital that looks after her over Aruna's own interests. The SC ruling is that in the case of an incompetent person, a next friend, who may be the guardian or the state, may be given the power to decide to withdraw life; expert panels with medical experts are to prevent misuse of this power.

The judgment has limited application and does not cover the plea for withdrawal of treatment by terminally-ill, conscious patients, a matter which has been treated as suicide. It also calls on Parliament to decriminalise attempted suicide; suicide in India is a criminal act though the irony is that only people who fail in their attempt can be punishable by law. The Law Commission report of 2008 states that criminalisation of attempted suicide has prevented provision of effective medical treatment to those who attempt it, and also hampers the implementation of efforts to prevent suicides. The report, while taking an empathetic view towards the person who attempts suicide, reaffirms that encouraging or supporting someone in an attempt to end his/her life is a punishable crime.

The author also discusses references to mercy killing found in different religious sects in India. In India where most healthcare is being privatised, the question of affordability of maintaining a terminally-ill patient on life support is being ignored. He argues that the denial of an option to end the life of a terminally ill patient is a denial of justice if there is no provision to provide healthcare for them.

Shukla R. Is the 'next friend' the best friend? *Econ Pol Wkly*. 2011 Apr 30-May 6: 10-13.

Semi-skilled doctors for rural areas?

Doctors are generally averse to working in rural areas. The number of doctors practising in urban areas is nearly four times that of the rural areas, while 75% of the population resides in rural areas. The Medical Council of India is trying to bridge the urban-rural divide by introducing a degree course of three and a half years' duration. Medical schools in district hospitals will offer the Bachelor of Rural Medicine and Surgery which would encourage students from rural areas to take up medicine and serve their own region.

The course material would be broadly based on the general medical curriculum. It would cover 60% of the syllabus of the medical curriculum. Graduates would be able to identify and treat common illness. They will not be able to undertake surgical procedures on patients

The advantages of this course would be that the rural population would be provided with skilled medical professionals. But their level of skill is something to be worried about. District hospitals are already burdened with their patient loads. Will they be able to offer a teaching facility to students? Would we not widen the rural urban divide by providing semi skilled doctors to the rural areas?

Garg S, Grover M, Singh R. Bachelor of Rural Health Care: Do we need another cadre of health practitioners for rural areas? *Nat Med J India*. 2011; 24(1): 35-7.

Should physicians defy the Hippocratic Oath?

This essay looks at the question of whether doctors should be allowed to administer fatal injections to death row convicts. The argument for doing so is that death row prisoners are like terminal patients and they should be given humane treatment even during execution.

Three sets of drugs are required to kill a person, and each set has its specific purpose. Sodium thiopentol is administered intravenously to anaesthetise the patient. Then pancurium bromide is given to paralyzes, and finally potassium chloride is injected to stop the heart.

The argument in support of doctor's participation is that only doctors can put convicts to death humanely. Improper administration of the drug would make death a very painful affair and only a trained person like a doctor should do it to reduce the condemned person's suffering. The argument against it is that doctors are supposed to treat patients, not kill them, and it is not ethically correct for doctors to carry out such acts under the state's instructions. It is also argued that these misdeeds may reflect in their practice.

The author concludes that capital punishment is against human rights, and we should first decide whether capital punishment should continue. If we cannot do away with capital punishment for heinous crimes then the execution of convicts by doctors is the best option.

Ashby B, Nelson L. Rethinking the ethics of physician participation in lethal injection execution. *Hastings Cent Rep*. 2011; 413: 28-37.

Maternal and child health in Brazil: still some way to go

Brazil has set an example for all to follow by replacing its multi-tiered health system with the Unified Health System (SUS) in three decades and offering universal healthcare coverage to its citizens. Maternal and child health is a leading parameter in measuring the true success of a nation's

efficiency in meeting its healthcare needs. Under the SUS, infant mortality rates dropped to 20 deaths per 1,000 live births in 2008; the prevalence of stunting in children under five years decreased to 7% in 2007; access to maternal and child health interventions increased sharply to almost universal coverage, and regional and socio-economic inequalities decreased substantially as a result of these. The average duration for which a child was breastfed increased from 2.5 months to 14 months by 2007. There is also a reported 4% decrease in maternal mortality rates.

However, even amidst all this brilliance, there is cause for concern: the overmedicalisation of childbirth in Brazil has reached a new high. Almost 50% of all births are through caesarian section, of which more than 80% take place in the private sector. This is much higher than in any other country, and far exceeds the 15% stipulated by the WHO. Section rates are higher among white, educated and upper middle class women. While in questionnaire-based surveys most would-be mothers document a preference for vaginal delivery, in-depth interviews suggest that women believe that caesarian sections are a safer and less painful form of delivery. Maternal deaths due to illegal abortions are also high and mostly unreported (since abortion, except for pregnancies caused by rape or when the woman's life is at risk, is illegal, even if the foetus suffers from severe congenital anomalies); and this form of death mostly afflicts non-white and rural women. The significant number of pre-term deliveries is also an issue that needs to be tackled. And despite the fall in the mortality rate of children under five years, the rate in itself is around seven times higher in Brazil than in countries with the lowest child-mortality. While countries like ours have a lot to learn from Brazil, Brazil itself cannot afford to be complacent. It has some way to go.

Victora CG, Aquino EM, do Carmo Leal M, Monteiro CA, Barros FC, Szwarcwald C L. Maternal and child health in Brazil: progress and challenges. *Lancet*. 2011 May 28; 377(9780): 1863-76.

Revisiting Chernobyl: effects on public health yet unknown

As we look back on the many nuclear accidents over the years, it becomes clear that the 1945 nuclear catastrophe was only the beginning. There was the United Kingdom's Windscale in 1957, the United States' Three Mile Island in 1979, the then Soviet Union's Chernobyl in 1986, and most recently, Japan's Fukushima in 2011. Yet, we are still to learn important lessons. In the case of Fukushima, the damage is yet to be measured.

There has been a failure of the international institutions expected to have tools in place for measuring the immediate and future impact of such incidents. The lessons learnt from Chernobyl too have not been used effectively to map the Fukushima disaster. Recently, an in-depth review of health-related research, carried out by experts under the auspices of a European Commission project, referred to the international response as "uncoordinated . . . forming a patchwork rather than a comprehensive, structured attempt to delineate the overall health consequences of the accident." Soon after Chernobyl, a professor from the Karolinska Institute identified an epidemic of stress-related disease attributable to public anxiety. This subsequently came to be known as the psychosocial effect, and is arguably Chernobyl's most serious health detriment to date, notwithstanding the more than 6,000 thyroid cancers cases. The health implications of Chernobyl have, since the incident occurred, been the "battle ground" for the lobbies for and against nuclear power, which seek to interpret the effects or absence of effects to their own advantage and are apparently unwilling to find the truth. Apart from exacerbating the psychosocial effects on those directly affected, this situation has prevented a comprehensive evaluation of the importance of the event to public health.

Baverstock K. Chernobyl 25 years on.*BMJ*. 2011 Apr 26; 342:d2443. doi: 10.1136/bmj.d2443.

Abortion: exploring more choices for women

The development of modern methods for medical abortion began in the 1970s. Since then, the drugs used have been refined and have led to safer abortions. Currently, medical abortion has become more common than surgical abortion, as it is also more cost effective. However, there have not been many studies to assess the risks and efficacy of medical abortion in adolescents. This retrospective cohort study examines this issue. Women must have more choices in abortions, since it is the larger issue of women's health and autonomy that is in question.

Grimes DA, Raymond EG. Medical abortions for adolescents: seems to be as effective and safe as in older women. *BMJ*. 2011 Apr 20; 342:d2185

Retaining staff under the National Rural Health Mission

Under the National Rural Health Mission (NRHM), the lack of skilled service providers in rural areas of India is a major challenge. The problem is more intense in tribal hilly areas of central India and the North-East. The authors look at this issue and come up with some solutions and lessons learnt on different approach of retaining health workers in rural India. The information was collected from a review of state programme implementation plans of the NRHM and from the responses to specific queries sent to state health directorates.

Since 2007, monthly financial incentives have been introduced for workers in difficult areas. Though the literature shows that incentives have a limited role in staff retention, the authors found that the schemes have been well accepted in all the areas. The authors apprehend that there is a temptation to consider the problem of retention as unsolvable. Another

approach in practice is workforce management by rotational posting in difficult areas, of course with a better residential infrastructure for all staff. Another strategy is to appoint staff on a contractual basis. There are some sponsored courses for those who are willing to work in the underserved areas. Continuous capacity building, including the rural medical practitioners and the field level health workers, is another alternative strategy. Though the authors found it too early to comment on all the strategies, they conclude that a regular evaluation has to be done for designing appropriate packages of retention strategies tailored to each state's requirements.

Sundararaman T, Gupta G. Indian approaches to retaining skilled health workers in rural areas. *Bull World Health Organ*.2011 Jan 1;89(1):73-7.

Time for new clinical research guidelines?

The authors discuss the International Committee of Harmonisation's guidelines for Good Clinical Practice (ICH-GCP), used as the golden standard for conducting a clinical trial anywhere in the world. They argue that the guidelines, though extensive, can be cumbersome and also do not cover all critical areas of clinical research. They are designed primarily for product registration trials, and cannot be applied by, say, a researcher testing a new approach like home-based care, or doing an observational study. Yet, interpretations of the guidelines to suit such contexts are considered suboptimal and often rejected. The World Health Organisation's research guidelines are no less difficult to implement; they are as rigid as the ICH-GCP. The so-called industry standards are expensive to follow and discourage local researchers from pursuing research to find cost-effective remedies for local problems. There is also a gap in capacity building of researchers in developing countries, as most clinical trials from developed countries are outsourced and conducted through contract research organisations. The authors argue that a more commonsense, simple and pragmatic approach is what is needed to facilitate clinical research in developing countries.

Lang T, Cheah PY, White NJ. Clinical research: time for new sensible guidelines. *Lancet*. 2011 May 7;377:1553-4.

Medical complicity in torture

Despite international laws prohibiting torture, such practices exist in various forms in various countries. Further, doctors may become unintentional accomplices when they provide medical care to those subjected to torture. This complicity is against international law and professional ethics. Doctors can find themselves coerced into being part of the team inflicting the torture. For example, in countries were amputation of limbs is a common form of punishment, it may be argued that a doctor should be present to ensure the wellbeing of the prisoner. There is also a dilemma as the professional code of ethics instructs the physician to restrain from being part of any torture and at the same requires that the doctor ensure that the patient receives proper and compassionate care irrespective of the circumstance, binding the doctor with the responsibility of ensuring the welfare of the prisoner/patient. Complicity in torture is also determined by the degree of assistance provided as well as the intention of the physician involved. Even though the torturer and the doctor might share the common goal of reviving the patient, the intentions might differ in that the doctor has the patient's welfare in mind whereas the authorities might be interested in interrogating him/her again. The consequences of the complicit action are personal, to the prisoner, and to the community.

Prisoner preferences are also factors which cannot be ignored while considering the ethics of medical complicity in torture. It has been recorded that doctors are able to talk to the prisoners about their treatment preferences even in the presence of security guards; however, this enquiry cannot be considered at par with the principles of autonomy and informed consent. It is also not clear how much the autonomy of the prisoner regarding his/her treatment is worth, and actual when the person is being tortured and his/her basic rights are being denied. There should also be a better international reporting system to which doctors can report incidents of torture without fearing for their own wellbeing.

Lepora C, Millum J. The tortured patient: a medical dilemma. *Hastings Cent Rep*. 2011 May- Jun;41(3):38-47.

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