FROM OTHER JOURNALS

Islamic ethics of organ transplantation[1]

The importance and relevance of religion to medical ethics cannot be doubted. What is the true role of a major world religion such as Islam in the newly expanding field of organ transplantation? We found a recent editorial informative.

Islam, Albar points out, is not only a religion but a way of life. Islamic ethicists have been active in recent years to resolve issues in medical ethics with special reference to emerging technology. Organ transplant surgery, though performed by many surgeons, including those in the Muslim world, for a long time, is included in this category.

Islamic principles related to this discussion pertain to the search for a remedy, finding the true value of a human being, saving a human life and the importance of brotherhood. Man should seek remedies against disease, which is a natural phenomenon. Blood and organ transplantation have been found acceptable. It is of interest that porcine bone grafts have been recorded in Islamic literature of the 13th century. In view of the recent controversy on xenotransplantation - especially the misadventure in Assam - one statement stands out:". . .Porcine xenografts and genetic manipulation may solve the problem of shortage of organs...cspecially hearts.. ."

The dignity of the human being must be maintained, both in life and in death. Autopsies, anatomical dissection and organ donation are accepted as they increase our understanding of the human body and help save lives.

Organ donation, however, must not harm the donor.

Finally, since the human body is the property of Allah, organ trafficking and commercialisation are unethical and explicitly refuted by Islam.

Market economies and primary health care in Viet Nam.[2]

The economic reforms introduced into South Viet Nam in 1986 and 1989 to reverse the disasters created during earlier years have resulted in some harm to primary health care.

Prior to these reforms, the government provided all health care. Currently, less that 20% of all medical treatment is provided by the public sector.

"In the public health service, physicians receive lower salaries... equipment is inferior.. . professionals experience tedium and believe that they are not valued... (as a consequence) they demonstrate a lack of interest in updating their knowledge and skills. These negative attitudes may be producing some undesirable activities such as the charging of extra fees...(and) referring patients for services to (their) own private clinics. Unscientific practices may be encouraged.. . including overtreatment.. . and inappropriate use of medical technology, pharmaceuticals and procedures to generate revenue from fees..."

Does this sound familiar?

Physician-assisted suicide (PAS)[3]

This essay opens a section of the Fall, 1996 issue of *Journal of Law, Medicine & Ethics* dealing with physician-assisted suicide. It focuses on dilemmas about PAS and care at the end of life. Questions addressed include distress in a terminally ill person, refractory to even the most skilled hospice care; dealing with requests from such a patient for a lethal dose of medicine; guidelines for PAS to prevent abuse and error.

Contributors include David Thomasma (Chicago), Jack Schwartz (Office of the Attorney General, Baltimore)., Franklin Miller and colleagues (including Timothy Quill) from the University of Virginia, William Bartholome (Kansas) and Diane Kjervik (Associate Dean, School of Nursing, North Carolina).

Guidelines already in use in the Netherlands and Australia are discussed. The Dutch government commission report released in 1991 showed that 2300 actual cases of euthanasia and 400 cases of PAS had been performed by then. The category of 'involuntary euthanasia' is briefly considered. Examples include the denial of treatment to a newborn with severe congenital abnormalities and avoidance of surgery in a patient with terminal cancer of the neck known to be eroding the carotid artery. When the artery does give way, the patient is treated with an increased dose of morphine.

Dr. Bartholome's essay is poignant as he has been diagnosed as having a fatal form of cancer and thus writes with deep insight.

Dr. Kevorkian's actions are also discussed and are compared with the less dramatic but more rational work of Dr. Timothy Quill and other physicians. Indeed, the summing up by Quill and his colleagues (page 232 of this issue) makes excellent sense: 'Some claim to be certain that PAS is a grave wrong and that it will careen us down the slippery slope. Others claim to be certain that we have a fundamental right to choose the time and circumstances of our death with medical assistance. We are persuaded by neither of these absolutes... The only way to test the validity of this hypothesis (legalise PAS subject to careful regulation) is by a readiness to experiment intelligently, to take the risk of being mistaken, and to make needed corrections based on our knowledge of the results.'

Placebos[4]

Freedman and colleagues discuss various aspects of the use of placebos in clinical research in two essays. Several myths are exploded. Whilst placebos remain useful, it is important to remember that a new drug is best evaluated by measuring it against the best existing therapy.

Critical care nurses and euthanasia, assisted suicide[5]

A public debate, especially in the West, continues about euthanasia. David Asch decided to investigate beliefs and practices of nurses who might have had the opportunity to practice euthanasia. Of 852 evaluable replies, 141 (17%) reported that they had received requests from the patient or family to perform euthanasia. 129 (16%) had acceded to the request. Some nurses even provided euthanasia **without** any request.

An editorial in the same issue (*Euthanasia and nursing practice - right question, wrong answer*) points out that such incidents do occur. It also suggests improvements in the questionnaire.

Russia today[6]

This review is recommended. Since the decline of communism, several unsavoury facts have emerged on the state of medical practice and research during the totalitarian regime. 'Soviet medical ethics did not protect patients from being used in medical experimentation without their consent or knowledge.. . Human beings were used in medical experimentation without their permission, explanation or indication of their right to decline.. The Nuremberg Code did not appear in print in Russia until 1993 and the first ethics committee was established in the Soviet Union only in that year.

Murder in a medical college[7]

Dr. Azariah recounts a recent murder in a medical college in Chennai, Tamil Nadu. The victim's 'crime'? Refusing to undergo ragging and torture by seniors.

Whilst medical ethical codes emphasise philanthropy and the principle *primum non nocere*, would-be doctors appear to revel in violence and mayhem towards their own colleagues.

It is high time that bioethics is introduced

as a subject in the curriculum of all our college courses - arts, science and medicine.

Ragging impinges of the fundamental rights of the student. If attempts at resisting such bullying brings on torture and death, what values are we imparting to our students?

Japanese guidelines on genetic counselling [8]

The Japan Society of Human Genetics has laid down the following guidelines:

Genetic counselling

1. Genetic counselling should be carried out by a knowledgeable, experienced counsellor.
2. Accurate and current information should be provided to those seeking guidance. Records must be preserved for at least five years.
3. The person seeking counselling and family have the right to know all about the prescribed tests and to refuse them.
4. Informed consent is essential.
5. The best interests of the subject must be protected at all costs.
6. If a test or course of action is against social and ethical norms or against the doctor's personal principles, the doctor has the right to refuse to administer it.
7. Personal genetic information is confidential.

Prenatal diagnosis

1. Prenatal diagnosis in the first half of pregnancy should be attempted if there is a strong possibility of the foetus harbouring a serious genetically transmitted disease.
2. Invasive prenatal diagnosis using amniotic fluid or sampling the chorionic villi may be considered only under special medical indications.
3. Except in the diagnosis of an X-linked disease, the sex of the foetus should not be revealed.
4. Efforts must continue to improve the accuracy of the results in prenatal diagnosis.

Ethics committees [9]

It goes without saying that ethics committees must be scientific and inbependent of economic or political interests. Hans-Georg Eicher writes, in a letter to the editor, that whilst the introduction of ethics committees in clinical trials is commendable, it is important to bear in mind some possible hazards - administrative or bureaucratic nuisance created by these committees and even scientifically incorrect conclusions.

Poor science is unethical and when ethics committees, themselves, display evidence of this, the blind acceptance of their authority harms institutions. Eicher suggests review of their decisions, perhaps by a supraregional ethics committee.

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Over the years, inspite of the fact that there is a growing belief that ethical standards are declining and therefore an apprehension that people's trust in doctors is being eroded, a recent survey in Britain indicated that about 80% of the people trust their doctors compared with 5% who trust politicians. I am unable to predict with any accuracy the results of a similar survey in our country especially at the present juncture.

Nevertheless it is axiomatic that the basis of any trust is the rapport built through a two-way communication between the patient and the doctor. Indeed, if we look at the main reasons for which patients sue their doctors, a study in the United States - the most litigious nation in the world - showed that the primary reason was not the medical injury itself, but the failure of communication. Patients sue because they were either treated with contempt or condescension or excluded from essential information and decision making.

What was more revealing was the observation that the vast majority of patients who did experience medical injury and negligence never sue their doctors. This may be because these patients trust their doctors and value their relationship which is personal, caring and respectful.

As noted medical educationist Eric Cassel observed, 'All medical care flows through the relationship between physician and patient. The spoken word is the most important tool in medicine.'

I must confess that this art of communication is least understood and practiced by our hospital consultants, let alone being demonstrated to their students. No amount of technological innovation or revolution shall ever be a substitute for the doctor-patient relationship built on mutual trust and sound communication. No amount of technology can ever be a substitute for trust. We should not let technology dehumanise medicine.

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