Principles of ethics in health care, November 22-23, 1997, Calicut, Kerala

Volunteer workers, social workers, nurses and doctors from different parts of Kerala, Nepal, the Maldives and Thailand attended this two-day meeting organised by the Pain and Palliative Care Society in Calicut as part of their workshop on palliative care for patients with advanced cancer.

A wide range of topics was discussed. The introductory session concerned itself with the evolution of medical ethics, modern concepts of the principles of ethical health care, morally valid consent and confidentiality. The subsequent panel discussion saw exchanges of views on justice in the face of scarce resources, listening to the patient, discussing serious illness and imminent death with the patient and relatives, and the need to tell the truth.

Euthanasia, brain death and organ transplantation were discussed during the second session. Relationships between patient and health care worker, (and between the health care workers themselves), doctors and the denial of the rights of the patient, medical negligence and malpractice, the ethics of medical research, commercial sponsorship of medical conferences and ethical dilemmas were taken up during the remaining sessions.

In the last session, proceedings were summed up and draft resolutions placed before the house were discussed exhaustively before unanimous conclusions were recorded.

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The Calicut Declaration, November 1997

I. There is a universal and permanent need for all health care professionals to be cognisant with the ethical basis of clinical practice.

1.1 Health care professionals will encounter ethical dilemmas during their practices. These must always be resolved in the best interests of the patients.

1.2. Disadvantaged patients (e.g. those with HIV/AIDS, the mentally ill or handicapped, the poor, the prisoner or victim of torture) demand the same high standards of health care as does the rest of the society. In addition, they deserve special compassion. It is unethical to discriminate against the disadvantaged in any way.

1.3. Although we learn from our ancient heritage and contemporary practice world-wide, it is necessary to devise Asian solutions to Asian problems, taking into consideration social customs, national differences, and economy, ie. realities.

1.4. It is important that we use cost-effective measures , drawing upon the strengths provided by close-knit family relationships.

1.5. There is need toincorporate the teaching of medical ethics into the undergraduate and post-graduate education of each member of the health care system. Structured training programmes must be supplemented by debates, discussions at the bedside and periodic consideration of actual or hypothetical situations that are encountered in practice.

II. The doctor-patient relationship must be one of partnership, founded on trust and fostered by honesty.

2.1 The inevitable inequality in the relationship necessitates an extra effort by the doctor who must do all he can to help without patronising.

111. There is a real danger of technology overpowering the dictates of common sense and reason. It is necesssary to ensure appropriate, relevant and cost-effective approaches to the diagnosis and treatment of illness.

3.1. Treatment of patients with advanced cancer demands special qualities of both the head and the heart. It is important to recognise the stage at which we must call a halt to tests and anti-cancer therapy. From this stage onwards, the goal is ensuring freedom from pain and other distressing symptoms.

3.2 Although life is precious, there is a time for each of us to die. In a terminally-ill patient, preserving life at all costs with high technology interventions is inappropriate; it is bad medical practice and therefore unethical.

IV. There is need to ensure equitable distribution of scarce resources so as to gain the maximum advantages for individual patients and society in general

4.1It is important to avoid the waste that is inevitable in duplication, the building of monuments to individual empires, and the setting up of 'mega-centres'.

V. Each member of the health care team is a specialist in her or his own chosen field and deserves respect. The team lader must be the first among equals.

5.1 The relation between the members of the health care team should be such as to promote learning from one another, mutual consultations, co-operation and efficiency — all focused on the welfare of the patient.

VI. Associations of doctors, nurses, other health-care professionals and voluntary agencies need to work in harmony with good communication between themselves and a commitment to patients and the general public.

6.1. Suspicion, paranoia about 'turfs' and 'territories' and vested interests have no place in ethical medical practice.

6.2 These associations must inform, advise and motivate bureaucrats and politicians so as to facilitate and bring into being facilities that benefit public health and the care of patients.

6.3 The associations need to work together to ensure human rights and to eliminate abuse, especially in relaton to the underprivileged, the poor, the aged, the handicapped, the ill and those deprived of their liberty by the state.

6.4. Steps to ensure openness in all activities in clinics, hospitals, asylums and prisons — and periodic public scrutiny with free publication of findings — are a necessary part of this programme.