QUESTION I EUTHANASIA

Literature

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G. Kelly, Medico moral problems, London 1960, p.115-127;

E. Healy, Medical Ethics, Chicago, 1956, p.266-271;

Ch. McFadden, Medical Ethics, Philadelphia, 1955. p. 140 - 160

J. Sanders, Points of Medical Ethics, CBCI Publication. p. 71 - 72;

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Medical Moral Problems, edited by P.Flood, Vol.III, London 1955; p.259 - 299;

Definition

Euthanasia in the strict sense:

To cause death (or assist in causing death) to a conscious certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death ("liberating death").

Euthanasia in wider sense:

a) To cause death at the instigation of pity - to an unconscious dying patient, to monsters, the seriously insane, etc. ("merciful death")

b) to cause death - for the sake of society - to asocial, dangerous persons, in general to persons who cannot live a moral life within the society ("eugenic death"). This causing death for the sake of the society may go to the extent of disposing of "useless" persons (aged etc) ("economic death")

N.B. "It is not euthanasia to give a dying person sedatives merely for the alleviation of pain, even to the extent of depriving the patient of the use of sense and reason, when this extreme measure is judged necessary. Such sedatives should not be given before the patient is properly prepared for death; nor should they be given to patients who are able and willing to endure their sufferings for spiritual motives" (Ethical and Religious Directives p.5, Cath. Hosp. Asc.U.S. and Canada)".

Anthropological facts history

Euthanasia, in various degrees, is found amongst primitive people both in East and West. It was practised in ancient Greece and Rome and considered by certain authors as honourable; the Judaeo - christian tradition rejected any form of Euthanesia as against the sacredness of Life (God being the author of life); Also hindu traditions stress the sacredness of life (respect for life).

Thomas More, in his "Utopia" describes how his "Utopians" (not he, himself!) accept euthanesia, when approval has been received from priest and magistrate. Francis Bacon, in his "Novum Organum" is the first in christian Europe, to plead for euthanasia, introducing the term.

In modern society euthanasia, in various degrees, has been practised, even to the extent of organised disposal of the unfit in Hitler's Germany.

> "To the extent to which **this** society is impregnated with materialism, the idea of collective efficiency dominates, as it did with the Ancients; the value of the person as an invividual is almost nil, and euthanasia tends to take its place in the juridical system under the mask of compassion. On the other hand, to the extent to which a society preserves spiritual values, the idea of efficiency yields to the respect due to the human person, qua person, whether he is weak or strong, dying or healthy; and euthanasia never receives legal recognition because the legislator rejects in it principle"(Flood, o.c. p. 270)

On October 17, 1950, the World Medical Association, composed of national medical associations of forty one different countries, in general assembly, adopted a resolution which called euthanasia "contrary to the public interest and to medical principles as well as to the natural and civil rights"(Jfr. Journal of the American Medical Association 144:1011, Nov.18, 1950; quoted Healy, p.269)

Points to be considered

1. Social consequences of acceptance of euthanasia:

From the sad, recent happenings in the West, all can easily learn to what terrible results in terms of human lives and sufferings the **slightest** deviation in moral principles is likely to lead. If euthanasia can be justified in one case, it can be justified in one case, it can be justified in others; it can be used to justify mass murder. Were it to be justified by the express consent of the patient, it could be justified by his constructive consent, and soon it would be justified against his express desire because as a useless being he would be considered obliged to give that consent. These horrible aberations are not mere theories we invent, but "facts of recent years known to the whole world" (Statement CBCI, 1953)

It is not realistic to expect that the dangers mentioned can be eliminated by 'proper' legislation. A. Bonnar, analysing the attempt to legalise mercy killing in England shows that the real aim of the movement is much more than **voluntary** euthanasia (A. Bonnar, the Catholic doctor, London 1951, p. 105 - 111).

2. Consequences for the medical profession in particular

The practice of euthanasia would greatly lessen confidence in physicians, for the patient who was gravely ill might readily fear that his physician would judge his case incurable and so administer poison to end his suffering. By no means unimportant to consider are the possible effects of legalised euthanasia upon the health of the people.

The elevated conception of the dignity and the high seriousness of the physicians calling were not easily gained. It was after centuries of convincing proof that the sole purpose if the physician was to prolong life and relive pain that medicine was able to advance. It was only after law no more demanded infallibilty on the art of the physcician, but only that degree of skill, knowledge and care commonly possessed and excercised by the average reputable practioner in the locality, that it was possible for medicine to improve the accuracy of diagnosis and to better the methods of its treatment, and that came about after only one development - absolute confidence that the aim,and only aim, of the physician was to prolong life and to relief suffering. Now there are those who would assign to the physician a duty of shortening it (Healy, p.269)

3. <u>Consequence for the welfare of the patient</u>

a) Euthanasia is bad medical practice. "The doctor must sustain hope for the incurable person". There are examples that an apparently incurable dying patient got curred; - revealing to a patient the fact that he is incurable may cause greater suffering and may become an obstacle for possible improvement.

b) Euthanasia is failing in true service. To assist a person in living up to the challenge of a very difficult situation (as an incurable illness is) may well be a greater help to the person than assisting him in escaping from it. "Man is not a mere animal; pain is not the greatest evil. Suffering accepted (from the hand of God) has an immense value for man" (cfr. points, p.72)

<u>Fundamental question</u>

A doctor does not deal with pains or deseases but with persons. His vocation, to assist the person who need his help, is not limited to assisting him in recovering health or aliviating pain but extends to assisting the person, in the way he can and as well he in the fulfillment of his fundamental task, which may include the duty to face suffering and approaching death.

Only if the patient has the right to die can a doctor assist him by causing death.

Therefore, the fundamental question is: has a man the right to end his life under certain circumstances.

"No one can give permission for murder; no private individual or public authority is allowed directly to take away or shorten life of an innocent person. To do so is an infringement of God's supreme domain over life and is this contrary to the natural moral law" (Statement CBCI, 1953)

Things are for man to be "used" and consequently can be disposed of according to man's needs. Man is not a "thing" to be used and consequently cannot be disposed of according to his needs or wishes. Man is a person. His being conscious free implies an unconditional task, the task to realise his true self in existing for the other (God, man), in the concrete circumstances in which he finds himself. This unconditional task implies; facing the challenges of life to the best of one's abilities under all circumstances.

NOTES ON "MEDICAL ETHICS"

P.N. The following notes; quotations etc., are meant as guidelines for discussions. A more comprehensive text on the various questions is found in the literature referred to.

The main purpose of the proposed discussions is to focuss attention on the specific character of an ethical approach to 'practical questions' and on the fundamental insights implied in any moral judgement.

INTRODUCTION: ON THE NATURE OF (MEDICAL) ETHICS

Definition of Ethics

Etymologically, the word 'ethics' refers to a) customs, manners (ethos) and b) inclinations; tendencies, attitudes (ethos). Thus the word 'ethics' indicates: a science of ways of behaving and of attitudes revealed in these forms of behaviour.

In our context, the term 'ethics' refers to: "the philosophic reflection on our being in this world, leading to an insight in the true nature of man and consequently to judgements on good and evil in man's actions and attitudes.

Explanation: Ethics is a philosophic reflection on being in this world. This reflection reveals that this being is: "an existing - at this world - with others - in God", - it uncovers the "idea 'behind' or 'in' our being in this world, - the "meaning of human existence", - "the nature of man".

Discovering the nature of man is discovering a task, - a task that gives meaning to our being free.

This task concerns man himself and can be described in general terms as "self-realization", - "becoming ones true self in existing at this world, with others, in 'God'".

This task is an unconditional task (duty), - a task which man 'finds' (objective ideal), - a task" to which man exists" (destiny).

It is in the light of a growing understanding of the meaning of human existence and consequently of man's fundamental task that we discern 'good' and 'evil' in man's actions and attitudes.

ETHICS AND SCIENCE

Though philosophy and science are both efforts to know and understand the world in which we find ourselves, the philosophic approach (method, attitude) differs basically from the scientific approach.

Philosophy is reflective. This reflection is a search for the meaning of human existence, - the true nature of man, - the values to be realised in man's actions and attitudes.

Science is observational. The scientist deals with the observable facts concerning man and the world in which he lives. In describing the 'nature of things' he actually describes what may be expected to happen in certain emperical situations.

Therefore: Whereas ethics reveals a task, - science deals with the emperical consequences of man's actions and attitudes. Whereas ethics uncovers the importence of man's actions in relation to his fundamental task (their "moral value"), - science, in describing the emperical consequences of actions and attitudes, shows their 'usefulness' with regard to desired goals.

For Example: various sciences deal with marriage, - they state the emperical implications (physical, psychological, social etc.) of certain ways of living. They teach how certain desired goals can be achieved and undesired situations can be avoided. Those sciences reveal the various possibilities regarding e.g.: marriage. These sciences, however, cannot reveal the meaning of married life, the 'idea', or 'ideal' that must become reality, in the actions and attitudes described by the sciences.

Ethics on the other hand, is concerned with exactly the meaning of marriage, - with the 'values' to be realised in this human encounter.

Ethics, however, presupposes science. For, ethics is not a reflection on an abstract idea but on a concrete reality, e.g. married life, in the concrete situation in which man finds himself. Scientific research is needed to get a better knowledge of the reality on which ethics has to reflect, that is: acts and attitudes in which moral values are to become real.

Using a traditional terminology we could say: science studies the "laws of nature", i.e. the properties of things, - how they will 'behave' in given situations, - "what will happen if.........."

Ethics studies the 'natural law", i.e. the 'nature of man' - how one should 'behave' in a given situation in order to realise the meaning of human existence in that situation.

ETHICS AND ANTHROPOLOGY

(Scientific) anthropology is a scientific study of man, describing his attitudes, customs- his judgements and feelings regarding forms of behaviour etc. As science it examines the origin and consequences of these attitudes etc. As science however, it does not judge these attitudes, judgements etc., in view of a philosophic insight in the true meaning of human existence. Anthropology is not ethics.

The conclusions of anthropology, however, will be helpful for ethics in so far they throw light on the human life on which ethics reflects.

ETHICS AND MORAL THEOLOGY

Moral theology studies man; the meaning of life in the light of religious traditions, e.g. in the light of the christian revelation: scripture and tradition.

The insights of moral theology, however, are of interest to Ethics in so far as a deeper knowledge of religious traditions (hindu, muslim, christian etc) gives wider knowledge of facts about man, and may direct and focuss our attention in the philosophic reflection. The conclusions of ethics, however, are not dependent on traditional judgement or specific religious experience.

ETHICS AND MEDICAL ETHICS

Medical ethics is ethics dealing with situations (actions, attitudes) typical for the medical profession. "Medical ethics" includes "medical professional ethics", that is: that part of ethics that deals with questions concerning the medical profession as such (e.g. relation to the patient, colleagues, professional secrecy etc.)

MEDICAL ETHICS AND "FORENIC MEDICINE"

Forensic medicine deals with legislation in medical matters. It studies the implications of existing laws and evaluates legislation on medical matters in relation to the common good.

Forensic medicine differs in purpose and method from ethics as it studies legislation not in relation to a philosophic understanding of the meaning of life, but in function of the common good, which is the purpose of law.

Though ethics and forensic medicine differ in purpose and method, the conclusions of forensic medicine are important for ethics as the legislation to which one is subject is a factor that must be taken into account in deciding man's duty in a given situation.

TRANSPLANTATION - THE MORAL ISSUE

INTRODUCTION: "As a result of medical progress, our technical decisions may become easier, but moral problems, on the contrary, will be increasingly significant." (Dr. J. Hamburger, ETHICS IN MEDICAL PROGRESS, Ciba Foundation Symposium, p. 136). Transplantation is one such field. Hundreds of people have been kept alive or helped to live because of transplantation of various sorts. Yet grave moral questions are being posed, and one reason for heart transplants going out of vogue, at least for the present, is precisely the ethical issue.

1. MEDICAL APPLIANCES: These are mainly of two kinds:

   a) Prostheses: i) Removeable e.g. dentures
   ii) Built-in e.g. orthopedic replacements, valves, etc.

   b) Artificial organs:
   i) Temporary e.g. heart-lung machine, artificial kidneys, etc.
   ii) Built-in: so far none are available for human beings, though an animal has been fitted with an artificial heart.

There is no special moral problem connected with the use of these, though the decision to use any of them is a moral decision that must be guided by moral values which must be upheld in all medical practice.

2. TRANSPLANTS: These are of three sorts:

   a) Auto-transplants: ie. those that take place within the body of the person himself e.g. skin, cartilege, bone.

   b) Homo-transplants: i.e. those that take place from the body of one person to that of another. These include: blood transfusion, organ grafting e.g. of cornea, kidney, liver, heart, etc.

   c) Hetero-transplants: i.e. those that take place from the body of an animal to that of a human person e.g. sex-glands, organs (incidentally, the first heart transplant ever performed was that of a chimpanzee's heart to a 64-year old man, in 1964 in the U.S.A.)

In the case of auto-transplants, we could follow the adage: "good medicine is good ethics". In the case of hetero-transplants, the grave question of possible "personality changes" must be considered e.g. Pope Pius XII stated that the transfer of an animal sex gland to a human being would have to be rejected as immoral because of the great disturbance to freedom which would likely follow. The integrity of personal life and personal identity prevail over prolonging life or any other possible advantage afforded by such a transplant. Finally, homo-transplants present more serious problems, and we must now consider these separately.

3. HOMO-TRANSPLANTS: The ethical situation changes with the source for obtaining the organ to be transplanted.

a) Cadaveric transplants: These involve tissues and organs removed from cadavers. It must be accepted that a person has the right to bequeath organs of his body for use after his death e.g. corneas. This would be an example of love for one's neighbour. In the case of a person who has not so bequeathed his body, the doctor must obtain the consent of his relatives to the use of any part thereof. The practice of presuming such consent, or acting without it (e.g. as happens in some teaching hospitals and research centres), is a violation both of the law and of the rights of the relatives. Since cadaveric transplants present fewer ethical problems, doctors should work towards making their use increasingly feasible, medically. There are indications of better prospects in this respect, especially with regards to the use of cadaveric lungs and livers.

b) "Free transplants": This refers to tissues and organs removed in the course of ordinary surgical operations e.g. when kidneys are removed in the case of urethral cancer or the creation of a subarachnoid urethral shunt. With our present scientific know-how, these present an advantage over cadaveric transplants because of the contractile nature of the organ, while, at the same time, they do not involve the ethical complications which are present in "living donor transplants" (see below).

c) Living donor transplants: This refers to tissues and organs provided by living volunteer donors. Cardinal ethical issues are involved here since it touches upon two individuals, the donor and the recipient. One has to consider the risks both to the donor as well as to the recipient.

4. HOMO-TRANSPLANTS -- TWO SPECIFIC AREAS THAT AROUSE ETHICAL REFLECTION.

a) Blood transfusion: This procedure has literally saved thousands of lives, has prolonged others and made possible major surgical operations. It provides one of the best ways in which a man can be a good neighbour. Barring serious accidents of typing, sterilizing and labelling, reactions are rarely serious and they occur in not more than in about 5% of transfusions. Th e overall mortality rate is probably not higher than 3 in a 1000. However, it is hard to be sure of avoiding the transmission of hepatitis, syphilis and malaria (in some parts of the world). Moreover, as we learn more about individuality in blood groups, the development of a dangerous sensitization is a risk always to be kept in mind. Finally, there is the danger of taking the procedure far too lightly: "topping it off" or "giving a pint more just to be on the safe side" has sometimes, ironically, resulted in death.

How does one act when the patient refuses to accept transfusion for religious or rather reasons which are not medical (e.g. Jehovah's Witnesses, or racial bigots who refuse to have blood from "inferior " races or castes) ? Should the doctor resepct the prejudices of parents, when saving the life of the child is involved; or, of an adult who refuses to be transfused?

i) Many feel that the parents' or patient's wishes should be respected, because they are considering not merely their physical welfare but their spiritual welfare and future life - and, therefore, this takes one out of the realm of medicine. No doubt one regrets being thus constrained.

ii) Others feel that the refusal of the parents make it a police matter, just as a proposed human sacrifice would be, and they would consequently seek a court injunction to carry on a transfusion. Strangely, the Courts of Law do not speak with one voice on this matter. Among the various reasons for authorizing a transfusion of a child despite the objections of the parents, is that the child is not yet free enough to choose its religious convictions, and, therefore, must be given a chance to live in order to choose its convictions. In the case of a mother who needed a transfusion and refused it, the court ordered it to be done, because the mother had no right to sacrifice herself and leave her seven-month child without her services. In the case of adults, one reason for upholding transfusion is that since an adult has come for medical treatment, and insists on it, he must accept the treatment advised and recommended. In any event, in the case of anyone who refuses a blood transfusion, the doctor who feels that he should not respect the wish of his patient (or of the parent of his child -patient) should seek a court order to do so.

b) Organs from living donors: Two questions have to be posed and answered:

1. Is the procedure justifiable medically?
2. Has the donor the right to mutilate himself?

In reply to the first question, the major consideration revolves around the immunologic compatibility of the recipient with the available donor-organ. Odds are presently about 100 to 1 that a recipient will get a tissue type that exactly matches his own. Hence, the doctor, who would like to do all he can for his patient because he has a deep and irrepressible concern for his patient's needs, should be careful to also consider more the immunologic - compatibility of the available organ than the need of the patient in itself. This would sometimes mean that a surgeon would be constrained not to transplant, since the well-being of a person is to be understood to be more than a mere prolongation of life. It is interesting to note that for kidney transplants, except in the case of identical twins, probably no more than 15 patients in the world have survived more than 3 years. "The procedure is of unknown value in terms of the five-year or ten-year prognosis" (cfr. ETHICS IN MEDICAL PROGRESS, p. 67)

In reply to the second question, two points must be considered:

a) The risk to the patient. It has been calculated that the risk of nephrectomy to the donor is as follows: 0.05% as a post-operative accidental risk, and 0.07% as the risk of any kind occuring later to affect the remaining kidney. However, this statistic must not be lightly interpreted, and physicians must have a conscientious concern for the better procurement of organs which will obviate the necessity of risking a healthy donor.

b) The consent of the patient. Especially in this area when the donation by a close relative, or twin, affects the saving of a life, it is difficult to assess the genuineness of consent. The donor can be pressurised both by other members of his family, who might even consider him expendable(!) and by an inner pressure exerted by his own social and religious education concerning the value of self-sacrifice, etc. The doctor should be specially sensitive to freedom of consent. Sometimes the help of a psychiatrist is enlisted.

While it remains true that doctors should work towards procuring organs from cadavers, the question remains: within our present limited options, can a healthy person donate one of his healthy organs to save the life of another? The answer would seem to be in the affirmative. For, if we could accept that a man can, in self-sacrificing love, "lay down his life for his friend" when this is an act of service to the other, we could also accept that he bee premitted to give a healthy organ to save the life of his friend. However, in arriving at this decision the following must be considered:

i) Is there a proportionately good reason?
ii) Is there a reasonable hope of success?
iii) Will the 'damage' caused to the donor be such as to prevent him from leading a normal human existence?
iv) Has his consent been duly obtained?

5. TRANSPLANTS IN THE "TWILIGHT ZONE" - LIVING PERSONS OR DEAD BODIES?

We said, above, that the procurement of organs from cadavers would obviate many an ethical difficulty. The question about the moment of death has become a thorny one in view of new procedures that can keep up certain physiological functions (heart beat, respiration) even though irreversible brain damage has occured. Physicians, lawyers, philosophers and theologians must apply their minds to a re-defining of "the moment of death". (See notes on EUTHANASIA for details about the criteria for determining the moment of death). This will affect the determination of the condition of the donor - is he alive or dead? But the central problems of organ transplantation will remain, and will have to be settled by different and independent norms (see below).

6. FINAL CONCLUSION: Once again in this question, as in so many others which we have considered in our course of Medical Ethics, we realize that there are disturbing cases in which the doctor cannot hope to find ready-made solutions by established standards. The dotor should guide himself by the basic principle of concern for the person of the other. On the one hand, then, he should beware lest " zeal for research is carried to the point which violates the basic rights and immunities of a human person"; on the other, he must work out together with experts from other specialities concerned with man (e.g. lawyers, philosophers, social scientists, theologians), some moral guidelines to assist him as he treads the paths of progress in medicine which he hopes will be to the benefit of man. Below is given, by way of example, a set of guidelines drawn up by two doctors with regard to transplantation of organs (cfr. Harmon L. Smith, ETHICS AND THE NEW MEDICINE, p 121)

1. Compassionate concern for the patient as a total person is the primary goal of the physician and the investigator.
2. Organ transplantation should have some reasonable possibility of clinical success.
3. The transplant must be undertaken only with an acceptable therapeutic goal as its purpose.
4. Risk to the healthy donor of an organ must be kept low, but such risk should not be a contra-indication to the voluntary offer of an organ by an informed donor.
5. There must be complete honesty with the patient and his family, including every benefit of available general medical knowledge and of specific information concerning transplantation.
6. Each transplantation should be conducted under a protocol which ensures the maximum possible addition to scientific knowledge.
7. Careful, intensive, and objective evaluation of results of independent observers is mandatory.
8. A careful, accurate, conservative approach to the dissemination of information to public news media is desirable.

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Medical progress is going to throw up many questions to which no preliminary system of medical ethics can provide immediate and certain answers. The ethical training of a doctor, then, cannot be limited henceforth to the teaching of a few ready-made rules. To quote Dr. J. Hamburger once again;

> "To produce doctors who are strong men, who are not only honest and just in thought, but efficient in action; to develop in them an awareness of the value of human life; to convince them that their vocation is an extensive obligation to the individual and to the group : such, it would seem are the best means of facing the ever increasing difficulties of medical ethics"
>
> (cfr.ETHICS IN MEDICAL PROGRESS, p.137)

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IN SEARCH OF A CHRISTIAN MEDICAL ETHOS

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AT a time when codes seem outmoded and almost inoperable, and ethics seems to be little more than a convenient way of doing business, when secularism is making inroads into faith, and religious indifferentism is gnawing away at the entrails of religious fervour and practice, it is an awkward question to ask : "Is there a Christian Medical Ethos ?" But, in an age of searching — inexorable, rigorous, incisive and honest — this question must be asked by every sincere Christian doctor, if he is to find meaning in his being both a doctor who is a Christian and a Christian who is a doctor.

About 20 years ago, at an international meeting of Christian doctors at Tubingen, Germany, the question was posed : "Is there a place for continuing to run Christian hospitals ?" Whereas some, among them clergymen, challenged the propriety of having 'Christian' hospitals, the assembly came to quite the opposite conclusion at the end of the meeting. The assembly of Christian doctors felt that there are problems, mysteries, perplexities connected with healing, living and dying, to which secular medicine has no answers, and upon which the Christian Gospel of the death and resurrection of Christ does throw light.

Is not this the perennial question we keep posing to ourselves : What difference does it make that one is a Christian ? Does his Christian faith make him a better, or different sort of, doctor than his non-Christian colleagues, leaving aside their respective technical competency or diagnostic skills ? A christian doctor must answer this question if he is to find the meaning and relevance of his faith in his professional life, and accept courageously and cheerfully the challenges that an increasingly secular climate of opinion and attitude will inevitably pose to his Christian conscience.

When speaking of 'difference,' we must beware not to think in terms of 'better' or 'worse'. The question, as C. S. Lewis rightly suggests in his book MERE CHRISTIANITY, is not whether being a Christian makes you a better man than someone else who is not, but, rather, whether being a Christian has made *you* a better person than if *you* were not a Christian. To use a commonplace medical analogy : to ask whether Miss Buxom is healthier or not than Mr. Pehlvan because she takes Multivits and he does not, is a meaningless question. The real question is whether Miss Buxom is healthier because of the Multivits than *she* would be without them. Hence, we should be asking ourselves whether the right understanding and living of Christianity makes better persons of us or not. In the same way, would it make a difference to the doctor's understanding of his role and mission in life that he has accepted the challenge of the Gospel, through a personal commitment to serve his ailing neighbour after the example of Jesus Christ ? Obviously, we are speaking not of the nominally Christian doctor but of one whose vision of Jesus, the Great Physician, brings him to see his calling to be a doctor as a *mission ;* of one who takes seriously suchlike sayings of Jesus to his disciples (among whom he counts himself) : "You are the salt of the earth. . . you are the light of the world." Such a doctor would legitimately be expected to ask : 'Is there a Christian medical ethos ?'

We must now explain the word *ethos.* An ethos is different from a *medical code,* or from *medical ethics.* Whereas a medical code provides the framework for the acceptable form of behaviour that would safeguard the doctor, the profession and the rights of the patient ; and medical ethics would represent the systematisation of moral judgements involved in making medical decisions ; an ethos is the value-system that influences the formulation of both code and ethics. The ethos is the way a man experiences, sees, and relates himself to, the world and to his fellowmen—is his fellow-man a thing, an object, to be manipulated and used for self-aggrandisement ; or, a rival over whom he must gain ascendancy, exercise control or wield power ; or, a neighbour, *his* neighbour, one who makes an imperious demand on his love and respect, one for whom he must care in his need, and for whose benefit he must strive to ameliorate the social and ecological conditions of living ?

It seems obvious that in arriving at an ethos particular to his profession, the doctor should consider not only the existing code, but also the convictions and ethical behaviour of conscientious colleagues. But, we may well ask, is this 'medical ethos' to be restricted to a lowest common denominator of accepted values? Can a doctor be satisfied with an ethos based on a moral values (if one could truly speak of such), on values determined by the *utility-*, or, *efficiency-*, or, *profit-*, principles that so regulate a materialistic society ? Can an "everybody-does-it" principle form the basis of a justifiable medical ethos ? Is there not room for a Christian medical ethos ?

DIMENSIONS OF A CHRISTIAN MEDICAL ETHOS

A Christian medical ethos must spring from the Christian faith. It must spring from the understanding the Christian doctor has of his vocation in the light of his faith. A Christian physician who models himself on Christ—whom Christian tradition has given the singular title : The Great Physician — would obviously have a set of values which he would not have, were he bereft of this faith.

1. *The Concept of healing :* To a great degree, the formation of a Christian ethos would depend on whether there is a Christian concept of healing. It is to be noted that a very specific sign of the Kingdom of God, mentioned in the Gospels, is the healing of the sick. Even the forgiveness of sins is linked with the healing process. "Go, sin no more. Your faith has made you whole" (where 'wholeness' refers to total well-being, which is an adequate definition of health). Is it too much of a surprise, then, to note that the ultimate injustice is described, among others, in terms of refusal of health-care : "I was ill and you did not come to my help" (Mt. 25, 43) ? A Christian doctor through his work of healing shares in the mission of Christ ; he proclaims the Good News through his ministry of healing, thus extending the frontiers of the Kingdom of God, or, if one dislikes the triumphalistic overtones, makes the kingdom more present among men. In this ministry, he is God's instrument, doing God's work of redemption. Both his personal life, then, and his dedication to his healing function, must proclaim

the presence of God. Besides, he will accept the obligation, before God, for the health of the individual for his *total* health as a *person*, and, through him, for all those who need his care. He is, in a word responsible *to* God, and responsible *for* his fellow-man's health, and is bound to provide the *best* ministration he can in the situation.

This last phrase may sound like a pious cliché, but, as a Christian, a physician must ask : "Before God, what is the best ministration in *this* situation ?" In other words, can one rest content with the *status quo* of current medical practice and accept the 'non-choice' approach that characterizes so much of today's medical services? Is the Christian doctor — and, by extension, the Christian medical institution and the Church(es)— to view his medical mission as meaning 'to provide the best care to those who *come* to him,' or, must he go further and assume responsibility for those, too, who do not come because they are either ignorant, or can't afford the fees, but are in fact most in need of his care ?

Our Christian concern must determine the way we fix our priorities. A pediatric Mission-hospital in Africa had an excellent record of service and of care provided to every child that was brought to it. At the same time, during the 50 years of its existence, the infant mortality rate in the area served by the hospital remained at around 282 per thousand births. While providing excellent care to the children, *brought* to the hospital, its authorities had failed to provide basic, life-saving care to the numerous children that were dying of 'neglect' in the surrounding area. It's excellent doctors were too busy saving a few at the expense of the many. In terms of costs, one could say that the cost of saving one child on whom, say, the equivalent of Rs. 500 was spent, whereas, if the same amount was diverted towards providing even basic medical care, ten children instead of one could have been saved, was, *in fact*, Rs. 500 *plus* 9 deaths. We need specialised hospitals and specialist doctors and excellent care ; but we also need to think in terms of the greatest good for the greatest number. It is a case, therefore, not of "either-or" but of "both-and." Incidentally, in the above mentioned case, the infant mortality rate was brought down to 78 per 1,000, within five years, through the action of a concerned pediatrician, newly arrived, who requisitioned the services of 15-year old girls, from the local mission school, to provide the basis of health education and health care. (This is a line of thought and action that GPs., with a large and comfortable practice, could fruitfully consider). We need constantly to re-evaluate our concept of "service" in the light of the Christian imperative of "caring." Perhaps we would find plenty of which to be ashamed in our "service."

The Christian's one guiding law is that of love, which someone has paraphrased as meaning : "to care enough about others as to want to do something about it." How does one "care enough" in a Christian way especially when we know that needs will always exceed resources ? There are no ready answers, but we must keep asking ourselves the question, often an agonising one. One suggested criterion for helping us fix our priorities is that of the "Poor." The "poor" are not necessarily the poor in any simple economic sense, but rather the neglected, the ignored, the rejected, the drop-outs of society, those who are not cared for and to whose care no prestige is attached. Where there is a pioneering need to do this, because nobody else will give attention to it, then it is a Christian calling. As Christians our particular, though not exclusive, concern is to care for those who are not cared for ! Each Christian doctor must listen for this specific call of God, in the secrecy of his heart, to such service within the framework of existing situations.

Another aspect to this 'service' must be considered. It is not always, nor only, a question of what a Christian doctor should do in terms of individual service. Practically speaking, much, in a developing country, has to be undertaken by Governmental agencies. The Christian responsibility of the doctor, then, would *also* consist in exerting himself to bring pressure to bear on the right spots, and on responsible persons in public office, to ensure that health-justice is provided for those who, in his Christian conscience he feels, must be cared for, and when such care can only be provided by public agencies. To give an example : concern for the rights of the unborn, in the face of liberal abortion legislation, must make Christian doctors want to do something about getting a different sort of social legislation (that would, for instance remove social stigmas like illegitimacy) passed, and about working for the setting up of counselling services for distraught women seeking abortion and Homes where, they may be helped to have their babies with dignity and without "fears."

The Christian vision of man, as it is worked out in the community of believers, must further influence the development of a Christian doctor's ethos. This understanding of man will bring special light to bear on some problem-situations, such as those which come up in genetics and human reproduction, medical experimentation and the dying-event. Further, it will affect one's dealings with one's patient, and the respect due to him coupled with the obligation of not taking advantage of his helplessness to feed one's greed. It will determine the nature of the medical secret, the obligation to respect the conscience of the patient, and his right to know the truth about his illness.

2. *Other dimensions :* One could bring within the scope of his Christian ethos the doctor's obligations to, and relationships with, his colleagues, especially the junior doctors who have to set themselves up. Too many doctors enter into a rat-race for patients, and bigger practice, at all costs! Not merely professional decency, but effective charity — really caring enough for one's colleagues, and their welfare, as to want to do something about it — should determine right relationships. Is "group practice" a Christian answer ? Or, entrusting part of one's burgeoning practice to a junior colleague ? Each Christian doctor must find his Christian answer to the demands of love in his own life situation.

Still another dimension is the Christian doctor's relationship with his own family. His absorption in his work, whatever the motive he professes, may make him not care enough for those for whom he is obliged to care. Further, living as he does in an underdeveloped country, the Indian Christian doctor cannot absolve himself of the obligation of thinking in terms of the needs of the country and the community, in fixing whether he is going to specialise or be a G.P., whether he will practise in the town or in the mofussil, whether he will serve in the country or go abroad (to get job-satisfaction, or to ensure the security of himself and his family). This is an *ethical* decision from which the doctor cannot escape, for, in fixing his "priority," he is determining the measure and quality of his service and charity. To be, in India, an U.S.-qualified neurosurgeon, *may* mean that one restricts one's service to a microscopic minority, composed in the main part of those who live in the larger metropolitan centres, and who can afford the fees. Of course, the country needs specialists — but the decision to be a specialist, or not, must be taken in accordance with his Christian vision of the demands of love in his life-situation.

Finally, his *Christian ethos* must make him care enough for himself, giving himself the time to relax and to pray, to build up the resources of his faith, so that the frustrations of growing in age may not make him a cause of *ennui* to others.

Conclusion : The Christian doctor, indeed, must keep searching for a specifically *Christian medical ethos.* His, faith, which he must ever strive to keep alive, must make him view his task not merely as a profession but as a calling, a mission, *i.e.*, a 'being sent forth' to carry out, in its total sense, the healing work of Jesus. While loyally giving ear to the teachings of the Church's Magisterium, he must remember that he too is a partner in listening, and active sharing, in the process involved in making *moral decisions* relative to complex *medico-ethical problems.* He must be prepared to, and, in fact, conscientiously ask, the daring, if upsetting, question : "What more does God expect from me?" "Am I *really* caring enough so as to fix the right priorities according to the mind of Christ whose minister of healing I am, and to the promotion of whose kingdom I must dedicate myself?" Many questions are unanswerable, or are not immediately answerable. That is the risk involved in the search ! But the search, in Christian tension, must go on and the Christian doctor must be prepared to act according to his Christian insights. A medical ethos based on such Christian Searching will certainly make a *difference*—hopefully, for the better !

THE FAMILY DOCTOR

(An Eulogy)

By Dr. Fred Noronha

IT is perhaps no exaggeration to say that no greater honour, responsibility or obligation can fall to the lot of a medical practitioner than to become a Family Doctor. For such an assignment, he needs not only the scientific skills of his profession, but also human understanding, courage, wisdom born of experience and emotional maturity if he is to provide this unique service to his fellow-men. The Family Doctor is not a mere healer of disease, he is also a friend, confidante and counsellor to the family he treats. He is, in fact, a privileged person. In his traditional role, he not only endeavours to prevent and cure disease, whether of body or of mind, but also enters into a more personal relationship with every member of the family. To him, each of them is a person and, he attempts not only to consider the physical and psychological problems of his patients, but also to view each of them in his correct perspective in relation to his environment, occupation, social milieu and genetic constitution, all of which may have a bearing on the health of his patient and, through him, on the health of his family. He gives them intelligent and humane care with tact, sympathy and understanding. For him, the patient is not a mere collection of interesting signs and symptoms arising from disordered function, diseased organs or distorted emotions, but a complete person, made up of body, mind and soul. He really cares for his patients ; a misanthrope could never be a good Family Doctor even though he might be a brilliant diagnostician.

A dedicated Family Doctor brings to the ailing patient and his anxious family a feeling of confidence and security. Illness often creates problems for the patient and members of his family such as, interruption of daily domestic or occupational activities, financial embarrassment, fear, anxiety or depression. Moreover, illness sometimes profoundly alters personality or constitutes a threat not only to the patient's bodily integrity, but also to his status in society. A person in such situations often seeks the help of another on whom he can rely as a trustworthy friend. The Family Doctor fulfils the need admirably.

The Family Doctor's grasp of the patient's personality, background, hereditary traits, environment etc.,, places him in the unique position of being able to know his patient in his totality, a fact which enables him to evaluate symptoms more accurately and intelligently, and often to diagnose an illness early. An early diagnosis generally implies less suffering, speedier cure and less expense to the patient.

Strange are the psychological attitudes which some patients adopt when ill. Some appear to take a secret delight in illness and resent anything that threatens their invalidism ; others refuse to face facts or bellittle their symptoms ; others again, try to adjust their distorted personalities to the environment by one or other of those devices known to psychologists as "mental mechanisms," and so on. These phenomena are not susceptible of solution by the use of precise scientific methods, but require profound experience of human nature, and some degree of maturity to probe beyond surface motivation and behaviour, see accurately and deeply the problems of another human being and tackle them satisfactorily.

One often hears of tragedy stalking unnoticed, in certain families, merely because its roots were not detected early enough or not at all. The Family Doctor has a grave responsibility in such situations. Fitted for the task by training and practical experience as well as his intimate association with the members of the family he treats, he often can and does detect the presence of an unwholesome environment or unhealthy trait or attitude on the part of one or other member of the family. It is not uncommon for an alert Family Doctor to avert or nip in the bud, by his timely intervention, an abnormal situation. Many a conscientious Family Doctor has saved an emotionally insecure child from future tragedy, effectively diverted a floundering adolescent from the path of delinquency, successfully advised against a hazardous marriage, averted suicide in a depressive, restored an alcoholic to sobriety, helped an elderly patient to lead a happier life despite his disabilities and performed a hundred and one intangible services which his unique relationship with the family made possible.

The Family Doctor is often faced with the sadder aspects of medical practice. Few problems are more distressing than those presented by the patient with an incurable or fatal disease. With tact, and deep understanding of human nature, the Family Doctor knows when, what and how much to say about the illness, to his doomed patient. The dedicated Doctor has often succeeded in bringing warmth and cheer to the patient and his family in such situations. He has to draw heavily on his humanity, mature judgment and intuitive talent on such occasions and be careful to avoid unnecessary psychic trauma both in the patient as well as in his relations by avoiding words and actions which are potentially introgenic. An indiscreet remark, a solemn bedside conference or an ominous frown For Examples could each of them cause untold harm to his anxious patient of his relatives. Yet he, owes a duty to his patient to encourage him to prepare himself for death both in the material as well as in the spiritual plane. When death occurs, there are the survivors stricken with grief who also need his attention. Often, he need not do or say much in such a situation, His mere presence and a few consoling words may help lighten their sorrow and feelings of helplessness.

The essential difference between the family Doctor and his other colleagues lies in the former's professional attachment to the family he treats . He is above all, a personal physician to the members of the house-holds, and his service is personalized. From this relationship there flows a two-way traffic between the Family, and the doctor. Genuine affection, mutual respect, loyalty, confidence and trust in the doctor on the one hand, and concern, sympathy, professional integrity on the other. Such is the foundation on which a most fruitful doctor-patient relationship thrives.

Some people, unaccustomed to the ministrations of a Family Doctor, might conclude that such an entity does not exist save as a figment of one's imagination. The fact is that changing patterns of society and a variety of other circumstances are creating an atmosphere in which the Family Doctor can no longer function qua Family Doctor and may soon face extinction. On the other hand, since no other system of medical care can fully and satisfactorily replace this unique institution it seems reasonable to expect a resurgence of the Family Doctor in future albeit in a new garb. The family Doctor of the future will, like his predecessor be a non-specialist and very human General Practitioner who will care for his patients and not merely treat them. He will of necessity, be equipped with superior training and knowledge, and adapt himself to an entirely new pattern of society. He will steer clear of all those influences which tend to turn him into a superb technician fit only for the practice of a soulless medicine and preserve the truly humane character of his noble profession.

GUILD NEWS

Our column 'Guild News' was held over for want of space in the past three issues. A brief account of some of our activities during the last quarter is given here:—

Annual Mass

The annual Thanksgiving Mass to celebrate the feast of St. Luke was held at the St. Xavier's College Chapel on Sunday, 17th, October. The Rt. Rev. Dr. Simon Pimenta, Auxiliary Bishop of Bombay was the celebrant and preached a very impressive homily. The fraternal repast followed at the college cafeteria. Welcoming Bishop Pimenta, Dr. A. C. Duarte-Monteiro, our President said that in keeping with the past tradition the Guild took the first opportunity to invite every new Auxiliary—representative of our Patron—as Chief Guest. His Lordship then spoke in glowing terms of the good work Bombay Catholic doctors were doing; he said he was happy to be admidst them and offer prayers for the living and the deceased members at the Thanksgiving Mass. Dr. C. J. Vas, Hon. Secretary proposed the vote of thanks.

Biennial Meeting

After breakfast, Members assembled at the College Council room. The retiring President was in the Chair. The Biennial report printed for the occasion reviewed the activities of the Guild for the two years April 1969 to March 1971. The audited Statement of Accounts, as well as the Report were duly approved and adopted. At the elections that followed, following Members constituted the new Executive Committee :—

Dr. Juliet De Sa Souza, and Dr. Eustace J. De Souza were elected President and Vice-President respectively; Drs. C. J. Vas, (Mrs.) F. de Gouvea Pinto, (Mrs.) J. N. F. Mathias and Terence Fonseca, were re-elected while Drs. Olaf Dias, Miss Charlotte de Quadros, Miss A.C. Duarte-Monteiro, and F. Pinto de Menezes were elected as new Members. Messrs. C. N. de Sa & Co. were re-appointed auditors, Dr. A. C. Duarte-Monteiro thereafter thanked the retiring committee for their assistance, and dedicated service rendered during the two years that elapsed. He recalled that he was President for four years, and he felt happy to hand over the Guild to his successor in a very good shape, judging from the activities undertaken, financial stability, solidarity as also relationship with the Junior Guild. He then vacated the Chair in favour of the new President Dr. Juliet De Sa Souza, who thanked all members for electing her unanimously, and assured them that she would maintain the high tradtions established by her predecessors. She referred to the dedicated service rendered by Dr. Duarte-Monteiro who gave a fresh life, full of vigour and colour to St. Luke's Guild. The meeting terminated with a prayer and vote of thanks to the Chairs.

Cardinal Gracias and Dr. Menino de Souza Felicitated

A special function—Tea-party—was held in the Junior Gymnasium Hall, St. Mary's High School Mazagon to felicitate our Patron, His Eminence, Valerian Cardinal Gracias, on his Episcopal Silver Jubilee, an also Dr. Menino De Souza on his being the recipient of Papal Knighthood. This function was fixed for the 23rd October last, the 71st birthday of His Eminence. Unfortunately he was not in town, as he had to attend all Sessions at the Synod of Bishops from 30th September to 6th November. On his return after five weeks he was caught—to put it in his words—"in the stream of deep anxiety for the future," The Indo-Pak conflict and circumstances that followed. Despite the fact that, 2nd of January happaned to be a day when there were several other functions in the city, St. Luke's Medical fraternity mustered quite a good strength with their families and children, in the nature of a large Family Gathering. The President Dr. Juliet De Sa Souza, gave expression of the feelings of joy of Members, and offered felicitations on behalf of the Guild to the Cardinal and chevalier De Souza. She referred to our Patron's keen interest and association with the activities of the Guild. She also referred to dedicated work of Dr. Menino De Souza in several spheres, civic, academic socio-cultural, and political, particularly in "fund-raising" for several charitable and educational causes. His Eminence, in a very eloquent reply, thanked the Guild for their greetings, and good wishes. Tracing his associations with the Guild from 1938, he congratulated the Members for maintaining a high standard which was due in large measure to the Presidents and the Committees. He said he was particularly happy to read the Guild Bulletin regularly since 1949 ; Stressing that the bulletin was indeed 'an accomplishment,' he exhorted members to see that it *appeared uninterruptedly*. Dr. Menino thanked the President and Members of the Guild for their felicitations and good wishes. He said he followed very keenly the activities of the Guild and congratulated the Committee for the progress they had made in recent years. He said Dr. Duarte-Monteiro, who was Guild President for four long years was greatly responsible to give it a 'new look' and a "good shape." Dr. C. J. Vas, the Secretary then proposed a vote of thanks.

The function—punctuated by recorded music refreshments, and variety of games for young and old—proved to be quite an enjoyable one due primarily to the efforts of the office-bearers, and assistance, of Drs. Terence Fonseca, Miss Carole Duarte-Monteiro, Denzyl Duarte-Monteiro, and young Fonseca. This may henceforth turn out to be a regular feature of the Guild, to enable members with their families meet at a *get-to-gether* during X'mas Season, and organise sports, games, or X'mas-tree for children.

FIFTH ASIAN CONGRESS FOR CATHOLIC DOCTORS

(Bangkok—1972)

The Fifth Asian Congress of Catholic Doctors will take place in Bangkok, early in December this year. It will be recalled that on the occasion of the IV Asian Congress held in October 1968, the assembly had unanimously authorised the Catholic Physicians Guild of Thailand to organise and play host for the V Asian Congress.

An unique feature of the Fifth Congress is that plans are formulated to include it in the First Ecumenical Conference of the Catholic Organization and the Christian Medical Associations in Asia, jointly sponsored by the Asian Regional Executive Committee of the FIAMC (International Federation of Catholic Medical Organisations) and the EACC (East Asian Christian Conference), although with a separate programme.

A Tentative Agenda of the Fifth Asian Congress is outlined here. Further particulars of the First Ecumenical Conference, as well as of the *Asian Congress of Catholic Doctors* will be given in our subsequent issues.

Tentative Agenda.

Subjects for discussion

1. F.I.A.M.C. Status and Bylaws (as amended and approved by the Convention 1970).

(*a*) Membership problems (National Organization and Fees).

(*b*) Regional Executive Committee problems (Meetings, cost for travelling, duties and obligations).

2. (*a*) How does the work of your organisation benefit from F.I.A.M.C.

(*b*) How can Catholic Medical Organisations in Asia benefit from one another.

(*c*) Closer relationship between Doctors, Nurses, and Para-medical workers.

3. Closer relationship among Chirstian Medical Organisations in Asia.

(*a*) Joint Regional Conference ?
(*b*) Joint National Conference ?
(*c*) Joint National Committee ?
(*d*) Joint Activities of National Level ?

4. (*a*) Election of Regional Executive Committee for Asia.

(*b*) VI Asian Congress—Where ? When ?

The Catholic Medical Bulletin

ORGAN OF THE CATHOLIC MEDICAL GUILD OF ST. LUKE, BOMBAY

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EDITORIAL

Our attention was drawn to the following comments in favour of 'mercy-killing' in 'The Times of India' under the heading "Human vegetables" (Current Topics, May 4th): "Thinking and talking about the unconventional may be distasteful to most people but this is an essential activity for man, the social and intellectual animal. Twenty years ago free and open discussions about sex or abortions were taboo, but thanks to the efforts of trend-setters such of the hypocrisy surrounding them has been stripped away. Euthanasia (or mercy-killing) is another subject which is still considered by confirmists to be unmentionable."

In support of his plea, the critic lays stress on the views of Lord Ritchie-Calder, the noted British science populariser and professor :—

"As a result of mental illness or degenerative diseases such as multiple sclerosis some unfortunate people turn into zombies; when advanced age compounds their disabilities, they become little better than human vegetables . . ."

The learned professor poses the following question :—

"How merciful is it to keep them alive with all the resources at the command of the modern medical practitioner ?"

Obviously the critic has considered man only from the socio-intellectual viewpoint, disregarding the ethico-moral, and even the rational one. The Catholic viewpoint considered from the latter angle, teaches us to respect human life, which is the basis for civilisation. Fortunately, in the same comments, while pointing out that "the Hippocratic oath prohibits euthanasia, the belief being that as long as there is a spark of life a man must be kept alive," he concludes that there is certainly another side to the problem, and that the issue needs to be openly debated in a calm manner. It will not be out of place to reproduce here what "The Himmat" writes in an editorial entitled "Of life and Death," wherein it compliments Pope Paul's firm stand on abortion and mercy killing :—

"The Vatican is to be complimented for its clear enunciation on abortion and euthanasia. In a letter to the International Federation of Catholic Medical Associations' meeting in Washington, the Pope said : 'Abortion has been considered homicide since the first centuries of the Church and nothing permits it to be considered otherwise to-day.'

As for putting those who suffer from incurable or painful diseases to death, His Holiness says :— 'Without the consent of the sick person, euthanasia is murder. His consent would make it suicide.'

Indeed a society where one satisfies one's desires without any responsibility for the consequences, and where the laws are created to encourage this irresponsibility, cannot be considered a mature and civilised society.

As an answer to the above question posed by the Professor, above referred to, we publish in this issue a talk given by the Chaplain of St. John's Medical College, Bangalore.

EUTHANASIA *

By Fr. Denis Pereira, Chaplain, St. John's Medical College, Bangalore

"DEATH in America," says a recent article in NEWSWEEK, April 6, "is no longer a metaphysical mystery or a summons from the divine. Rather it is an engineering problem of death's managers—the physicians, the morticians and statisticians in charge of supervising nature's planned obsolescence. To the nation that devised the disposable diaper, the dead are only a bit more troublesome than other forms of human waste." And a little later, quoting an American psychologist, the article goes on to say : "The dying no longer know what role to play. Most of them are already old and therefore worthless by our standards. There's simply no place for a human death when the dying person is regarded as a machine coming to a stop." (Kastenbaum)

It would seem clear from the above that any discussion of euthanasia must necessarily be preceded by agreement on a proper philosophy or theology of death. What does death mean to us ? Is it 'a machine coming to a stop?' Does it merely provide 'a bit more troublesome form of human waste?' or is it "in the eyes of us doctors, the great enemy against which we must fight with all our resources, backed by patiently acquired knowledge," and if so "is it reasonable that we should be indignant, that we should indulge in barren irritation, before this inescapable condition of human existence ?"

"Death" says Francois Mauriac, "is that terrible thing that happens to other people." In a world frenzied with the pursuit of pleasure and comfort, obsessed with its egotism, "death is an affront to every citizens' inalienable right to life, liberty and the pursuit of happiness." (A. Toynbee speaking of 'Death as being un-American'). But for the Christian, and the man of faith, death is not the end but a stage in living—the process of dying is in reality the art of living meaningfully in and through the process of dying. Death is the gateway of eternal life. It is the moment at which we ratify the fundamental options we make in life. If 'to live is to choose,' then to die—if that death is human and meaningful—is also an act of choice in simple words, a truly human death is one in which one ACCEPTS to die. This is what Dr. Elizabeth Kubler-Ross, in her book ON DEATH AND DYING hints at when she quotes one woman, who finally bowed to the sentence of death after steadfastly refusing to accept the fact of her impending death, as saying: "I think this is the miracle. I am ready now and not even afraid any more." She died the following day. It is to be noted, however, that the acceptance of death is not to be taken to mean that the person has the right to impose death on himself, to ask another to shorten his life, or to place in another the power to end it ! We have no right over life, even though we may have at times a right to die ! And this brings us to the question of euthanasia.

Etymologically, the word EU-THANASIA means

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* Talk to St. Luke's Medical Guild, Bangalore, on April 22, 1970.

"dying well" But that is not what it has come to mean in legal or medical parlance. From its original meaning of "dying well," a perfectly innocuous and healthy philosophical value, it has come to mean "easy dying," which is not the same thing, for this implies medical intervention to cut short the process of living in order to accelerate or rather induce death. Other words used to describe it are "mercy-killing," "merciful release," "voluntary euthanasia" or "easy death" (which, incidentally, is the name of a society started in England in 1935 to push euthanasia legislation through Parliament). and "the termination of life by painless means for the purpose of avoiding unnecessary suffering." It is easy to see how 'mercy killing' can turn into 'convenient killing'—but let me not anticipate.

A. EUTHANASIA in the strict sense means : "to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death." Here we can distinguish between 'direct euthanasia', *i.e.* where the assistance is rendered intending death. This is murder, or cooperating assisting in suicide, or both, and is never allowed. And we can speak of 'indirect euthanasia' or the administration of treatment (*e.g.* to alleviating pain) with as a side effect, the acceleration of death. This last would better not be called 'euthanasia' at all. J. Fletcher calls this antidysthamasia' (not prolonging the process of dying). "It is not euthanasia to give a dying person sedatives merely for the alleviation of pain even to the extent of depriving the patient of sense and reason, when this extreme measure is judged necessary. Such sedatives should not be given before the patient is properly prepared for death, nor should they be given to patients who are able and willing to endure suffering for spiritual motives." (Directives Catholic Hospital Association, U.S. and Canada). It is obvious from this directive that the person must be helped to live meaningfully through the process of dying. The real problem is: to what extent must a doctor/patient prolong life? Always and at any cost? We could perhaps be helped if we distinguish between 'Prolonging life' and 'prolonging the biological process of dying'; or to put it in other words, we could visualise cases in which the prolongation of biological life may not really be 'living meaningfully,' whereas acceptance of death may be 'living this moment as a human being' even though biological life is shortened (of course without being directly terminated, which is plain murder even if done with the consent of the patient.)

Take the case of a dying person who is ready to die and wants to die. He is suffering. He is surrounded by medical apparatus. He has hardly any contact with his environment, his friends, his family. His children are kept away, and visitors not allowed. Would not a doctor be justified in instructing the nurse to take away the instruments and allow the children to be with the father even if this may well mean an earlier death? Indeed, this may well be the best way to help a person to live—through the process of dying meaningfully, even though the duration of the process is shorter. Keeping a person alive is not necessarily helping him to live, for living means more than biological survival. And in this case the duty of living becomes the duty of dying well. (The question as to whether a patient is bound to accept, and the doctor bound to prescribe, extraordinary means to prolong life could be discussed in this context—but this would take us far out of the scope of this talk.)

To summarise this part, I will now read out some norms with regard to "indirect euthanasia."

1. "A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

2. Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community; its members are not bound to prolong the agony for a human being.

3. There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available . In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances." (L. Orsey, S.J.)

4. "I would urge that we promote the idea of *bene mori*, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. 'Bene mori' that is allowing the patient to die peaceably and in dignity is always justified." (J. R. Cavanagh)

[*N.B.*—This conclusion presupposes (1). that all concerned act in accordance with the will of the patient; (2). that the patient is dying. The dying process is the time in the course of an irreversible illness when treatment will no longer influence it. Death is inevitable.]

B. EUTHANASIA IN A WIDER SENSE: Euthanasia in a wider sense is less complicated to deal with ethically. It includes:

(*a*) To cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.

(*b*) To cause death, for the sake of society, to a socially dangerous person, to persons, in general, who cannot live a moral life within society (the so-called 'eugenic deaths'). This causing death for the sake of society may go to the extent of disposing of "useless" persons, the aged, etc.

One can easily see, especially in the light of the Nazi atrocities of World War II, how fraught with terrible consequences the admission of such a principle would be ! "From a purely medical point of view shortening or taking the life of a patient for the relief of pain is unnecessary. Moreover, it is a confession of professional failure or ignorance" (Dr. Graham). Further, "the practice of euthanasia would lessen the confidence of patients in their physicians, for the patient who was gravely ill might readily fear that his physician would judge his case incurable and so administer poison to end his life" (Healy). One could imagine the confidence one would have in confessional practice if the priests were sometimes justified in betraying the confessional secret. And lastly, as B. Bonhoeffer who was himself executed in a German prison camp, put it: "we cannot ignore the fact that precisely the supposedly worthless life of the incurable evokes from the healthy, from doctors, nurses and relatives, the very highest measure of social self-sacrifice and even genuine heroism," and, we may add, has been the inspiration for much real research and advance in medical knowledge and practice (cfr. the heart transplant surgery by doctors who "would not give up"). Truly, euthanasia is bad medical practice.

Conclusion : In the course of the last few months, two of the Associate Professors of Medicine of our College, both excellent Hindu gentlemen, addressed our pre-professional class students. One of them, when asked about euthanasia said he would never practice it, because it was a doctor's duty to protect life, and he would work to the end to prolong it ; the other, with touching candour, said : 'There are times when I can't help my patient to live longer. At those times I must know how to assist my patient to die well, saying the right word of encouragement and helping him to accept his sufferings.' In the face of death, this is exactly what a doctor should do. "We have helped our patient" writes a Catholic Doctor in an article in CAHIERS LAENNEC, December 1946, "in his suffering; we now help him to die, to die well, or more truly to be born again into eternal life." And he adds in the same article : "do not let us change by a merely spectacular attempt at medical intervention this last and precious contact between the living (*i.e.* the patient and his family), and this final possibility of colloquy with God on which eternity depends . . . . Shall we by a gesture aimed at the entourage, rather than the patient, and which does not even hide our human medical impotence, shall we run the risk of obstructing the light of this last vision of God, and thus prevent an adherence which often remains . . . the assurance of a happy eternity for the patient ?" Notice, the emphasis on the patient's right to die a human, meaningful death. And he concludes, and with this so do I, "in the apprehension of these serious realities, let us, on the contrary, pursue to the end our true role as doctors—our role of respect for life—towards all and inspite of all. . . The tranquil death which we desire for our patients, as for ourselves, is not necessarily the unconscious death which drugs, even prudently administered, can procure. We ask above all, a peaceful death with the soul at peace and abandoned to goodness and mercy which opens to it the gates of eternal life. The sweetness of death is in that vision of light and life."

AMONG THE REFUGEES

By. Dr. Henrietta Moraes

THE poor intern is considered neither a student nor a doctor. His budding potentialities are underestimated, and though he himself may overestimate them a wee bit, few realise the enthusiasm and dedication with which he could perform perhaps a few small wonders in any medical situation—if only he were given a chance.

When I heard of the urgent medical need of the Refugees, I was drawn by sympathy and also by the challenge it offered I was full of enthusiasm, prepared to fight against the diseases of the refugees and to make myself feel worthy of being a member of the medical profession.

The Bombay University was preparing to send a few male interns but with its usual fatherly and dogmatically conservative attitude, it refused to send interns of the weaker sex (though after a lot of consideration, it has just sent a few lady doctors too). Everyone at home, supported by a host of friends and relatives, decided that I would not return in one piece if I left. Finally after a lot of persuasion and many promises that literally bound me to spend more time safeguarding myself, I was allowed to go. I am very grateful to the Indian Catholic Charities—Caritas, for it was through them that I left.

I travelled to Calcutta with two compounders who had also volunteered. At Calcutta, where Caritas has its headquarters for its Refugee Relief Work, it was decided that we work at the Salt Lake Camp. There were many volunteers who had come through Caritas from all over India and abroad to help in the relief work. It was wonderful meeting these people who had come with an abundance of enthusiasm, cheerfulness and selflessness to volunteer in the service of the refugees. I would love to mention them here, but perhaps I dare not, for I could never forgive myself if in my thoughtlessness I mentioned some and forgot a few.

It was truly this spirit of dedication, co-operation and thoughtfulness on the part of the volunteers towards the refugees and to each other, that got us so involved in the relief work. One realised that however vast and urgent a situation, nothing could be achieved without some organisation and co-operation.

There were over 900 camps all along the eastern borders of West Bengal, Tripura, Assam, Meghalaya and Bihar. Most of the camps were organised by the government mostly through the individual State Governments. The government spent a great deal by way of shelter, food rations, immunisation and sanitation programmes in most of the camps. On an average the government spent Rs. 3 a day on each refugee and at present we have nine million ! The Indian Catholic Charities—Caritas was also doing a tremendous amount of work in looking after about 70 refugee camps. A number of other organisations such as CARE, CASA, OXFAM, Medico International, S.C.I., Red Cross, Hindustan Steel, Ramakrishna Mission were also very active. It provided, medical aid, shelter, clothes and food to the refugees. Salt Lake which was one of its biggest camps, was nearest to Calcutta and supplies were therefore brought in more easily and regularly. Transport to the camps further north was difficult and made worse by the floods. In addition, those camps also dealt with a continuous influx of fresh refugees under a persistent fear of military attack.

My first visit to the Camp created lasting impressions on me. I still remember walking through the sands of Salt Lake towards the camp. There stretched before us miles of endless barren sandy land with not a tree to be seen except for a few on the distant horizon. But this very land was teaming with two hundred thousand refugees trying pathetically to adapt themselves to hostile conditions. We could see hundreds of little tents huddled closely together and endless rows of barrack-like sheds built of bamboo-matting covering the shed completely except for the many little doors. Each door led into a dark damp area of about 20-30 sq. feet. One could see a few sad faces of the inmates peeping through and viewing us with an air of aloofness ; women garbed in tattered clothes and burdened with naked hungry-looking children, spiritlessly trying to light a fire with a few damp twigs or coaxing a listless child to eat what little food they had. Some of the children, with the starvation and hardship they had gone through, wore the brooding expression of the old on their sunken faces. One hardly saw little children playing together. There was no trace of curiosity or cheerfulness in their expressions.

Fresh arrival of refugees brought a wave of depression upon us. But it was something we were always to see. They had treked wearily with their bare feet blistered and swollen and with hardly any clothes. When it rained, their meagre flimsy clothes clung to their skins as they walked along at the same weary pace, in no hurry to seek shelter. There was hardly a day that a complete family arrived at the camp. We would often see a woman alone with her children and perhaps an old helpless relative. Many of the men folk had been killed, some had stayed behind to fight. Occasionally, a woman would tell us that her child or parent had died on the way, of exhaustion and starvation, or that she was not sure of the existence of her husband or older sons. And then some would beat their heads to the ground and cry helplessly. The refugees were so reconciled to their fate that it was really heartening when one saw a youngster helping an old disabled man to the dispensary, or a few little boys fighting to get into a puddle of water or a group of young girls peacefully singing a few songs.

The future held no promise and they were so bereft of emotion that one rarely saw one refugee voluntarily helping another.

Of the refugees, ninety per cent were helpless women and children and the same percentage of them were Hindus. Most of the refugees at our camp were illiterate. Most were landless farmers by occupation and very few had an occupation or trade.

Our greatest problems were nutrition, unemployment, sanitation and the continuous arrival of more refugees. Conditions were such that men worked for no payment. Every morning there were crowds of men waiting to be employed but so many had to be turned down. They were not permitted to go into the city to beg or work as there was so much unemployment among the local people themselves. To keep the refugees occupied arrangements were under-way to start schools for the children with the few educated refugees as teachers. Parts of the camp were cleared up for play fields for football, etc. There were sewing classes for the young girls and women. The men would soon be employed in bamboo matting.

Endless hours were spent by the refugees in patiently standing in unending queues, often in the scorching sun or heavy rains, for bread, rations, medicines or water. Caritas was supplying 20,000 loaves of nutrified bread daily. Even though one loaf was given to every four persons, there were many who went without bread and waited their turn the next day or the day after that. Each time they received the bread it was ticked off on their ration card.

We had a well supplied dispensary with a separate shed for minor surgery, bandages and injections. We examined about 600-700 patients a day.

We would go out every few hours among the queues and bring in the serious patients who often without murmur would patiently wait their turn. These patients would be admitted to our hospital. It gave us such joy when we were able to save many of them with the wonderful drugs and other medical aids that had been donated so generously by countries all over the world. We had a simple but fairly efficient numbered card system for the out-patients and we even kept an out-door and in-door patients register.

We realised how a few friendly words and a little attention could go a long way to make these lonely sick people feel better. This was brought home to us even more strikingly by a middle-aged man suffering from cirrhosis of the liver. It was a chronic illness and there was not much that we could do for him. As he had no one, to care for him, we let him remain in the hospital. When he made a nuisance of himself, we did not hesitate to shift him to a small empty tent. That night he hanged himself. This had such an impact on all of us that it made us feel guilty. Frustration may have driven him but if we had been a little more friendly and attentive we could have saved him. We immediately decided to reserve two big tents for those old and chronically ill patients who had no one to care for them.

Our hospital housed two hundred patients in a few sheds and tents. We had two tents for maternity cases ; two tents for the old refugees ; two sheds for children; one shed for adults and one for patients with diarrhoea. With the admission of many of the patients we had the rest of the family in the hospital too—living round the patient. If the mother accompanied the sick child there was often no one else to care for her other little children. Most of the patients were admitted for pneumonia, typhoid, cholera, dysentry, nutritional deficiencies, measles, chicken-pox and infective Hepatitis. Diarrhoea in children was quite the most persistent problem and would remain so with poor sanitation and nutrition. We had transport at our disposal throughout the day to transfer patients with acute surgical problems to the city hospital. If it was not for the dedicated work of the Sisters of Charity, the volunteer nurses and helpers (among them many were refugees) it would not have been possible to run the hospital.

The dead bodies from the hospital and camp were kept in a tent among sacks of sulfur and bleaching powder till they were disposed off. The refugees had been deprived of their Motherland and later their dear ones. It was only death that emotionally moved these people—but only into a deeper and unapproachable gloom.

One cannot say what the future holds out for the refugees—but with the blood, sweat and tears that these people have shed, we with them pray that Bangla Desh will be a reality.

I had spent one month with the refugees and though there was heaps of hard work we had our moments of happiness too. Caritas had provided all its volunteers with homely and comfortable quarters. Returning back after a heavy day's work or a strenuous night duty we were always sure to have waiting for us just the things we desired most. Our experiences at Salt Lake will remain as vivid memories never to be forgotten.

OUR FELICITATIONS

We offer our congratulations to the following students who have passed the University of Bombay Examinations held in April 1971 :—

Third M.B.,B.S.

Miss Premila Robert D'Silva
Miss Philomena Faustine Lewis
Mr. Eric Joseph Francis Pinto
Mr. Vernon Patrick De Sa
Mr. John Austin D'Souza

Second M.B.,B.S.

Miss Mary Margaret Carrasco
Miss Maria Prisca Colaco
Miss Sandra Frank De Souza
Mr. Chipriano Serafinho Fernandes
Mr. Gregory Michael Fernandes
Miss Aruna M. Fernandes
Mr. Christopher Joseph Lobo
Mr. Gilbert Dominic Lopes
Miss Alzira Francisca Mascarenhas
Miss Sarita Joan Noronha
Mr. Arun Charles Pinto
Miss Lorena Siqueira

No Candidates appeared for the First M.B.,B.S.

Our 20th Annual Social Gathering

Members of the Senior and the Junior Guilds, are hereby informed that the St. Luke's Annual Re-union will be held at the Bombay Presidency Radio Club, Colaba on the 4th December, with Nelly and her Orchestra in attendance. For further particulars kindly contact the Chairman of the Entertainment Committee, Dr. (Mrs.) Francisca de Gouvea Pinto (Phone No. 371630), or any of the following :—Dr. F. Pinto de Menezes, Colaba (No. 213010); Dr. Terence Fonseca, Byculla (No. 377264); Dr. (Mrs.) G. Silveira, Mazagon (No. 372958) ; Dr. John Fonseca, Mahim (No. 455623) ; Dr. (Miss) Charlotte De Quadros, Bandra (No. 533103) ; Dr. John V. Ribeiro, Santa-Cruz (No. 538877) and Dr. A. A. Soares, Chembur (No. 521352). Students may please contact representatives in the respective Medical Colleges.

AN APPEAL FOR HFLP TO THE REFUGEES

It will be recalled that at a Meeting of various organizations of Bombay's Medical Practitioners held on th 9th April, 1971, a Committee known as the 'Bomba Medico Bangla Desh Aid Committee' was formed, an it was also decided that medicines and money be collected to help the refugees.

At another meeting of the representatives of St. Luke's Medical Guild, the Catholic Nurses Guild, the Catholic Relief Services and Caritas India, held at Archbishop's House on June 22, it was decided to appeal to Catholic Doctors including Interns, as also to the nurses and compounders to work as volunteers among these refugees in Bengal. It is heartening to note that a batch left Bombay on the 12th July, 1971 in response to this appeal. However, the need for volunteers continues more so because replacements will be required for those who are due to return on the completion of their period of service. While appreciating the generous efforts of our members and their families to alleviate the suffering of these refugees, we urge them to continue their activities in the collection of drugs, surgical dressings, clothing, coverings (particularly blankets), mats, sheets, sarees and the like, and deposit the collected articles at any one of the centres given below. For the convenience of members there are three different localities, North, South and Central :—

1. St. Peter's Parish (Bandra), for the suburban members.
2. Sodality House (Seva Niketan), central areas.
3. Nirmala Niketan (School of Social Work), 38, New Marine Lines.

A. C. DUARTE-MONTEIRO.

MEDICAL EXPERIMENTATION

(Below are given excerpts from an excellent book by an English doctor who spent years studying this subject and kept a bulging dossier on the same. Many moral principles are highlighted which have relevance to the whole field of medicine. It is to be hoped that the reading of these notes will be profitable to all doctors and medical students.)

relevancy to the whole field of medicine." Surely it will be very profitable to all doctors and students who read it.)

HUMAN GUINEA PIGS

by Dr.M.H.Pappworth
(Penguin Books)

THE PROBLEM: For several years a few doctors in this country and in America have been trying to bring to the attention of their fellows a disturbing aspect of what have become common practices in medical research. These practices concern experiments made chiefly on hospital patients, and the aspect which is disturbing is the ethical one. In their zeal to extend the frontiers of medical knowledge, many clinicians appear temporarily to have lost sight of the fact that the subjects of their experiments are in all cases individuals with common rights, and in most cases sick people hoping to be cured. As a result it has become a common occurrence for the investigator to take risks with patients of which those patients are not fully aware, or not aware at all, and to which they would not consent if they were aware; to subject them to mental and physical distress which is in no way necessitated by,and has no connexion with, the treatment of the disease from which they are suffering;and in some cases deliberately to retard the recovery from that disease so that investigation of a particular condition can be extended. (p.15)

SUMMARY OF VIEWS ON MEDICAL EXPERIMENTATION: 1)Clinical research must go on,but there must be acknowledged and observed safeguards for the patients. At present such safeguards are virtually non-existent. 2) The majority of those engaged in clinical research act with the highest moral integrity,but an expanding minority resort to unethical and probably illegal practices. 3) Unless the medical profession itself stops the unethical practices of this minority,the public outcry will eventually be such as to cause opposition to all clinical research (p. 18)

"It behoves the medical profession to take the public into its confidence. The primary step is to recognise that difficult moral problems - indeed the moral dilemma - do exist for which help and guidance can be sought from many sources. In the end we have to accept the fact that some limits do exist to the search for knowledge."(Prof.P.A.Freund - Lawyer) (p.20)

WHAT CONSTITUTES A JUSTIFIABLE EXPERIMENT? "The science of experimental medicine is something new and sinister;for it is capable of destroying in our minds the old faith that we,the doctors,are the servants of the patients whom we have undertaken to care for,and in the minds of the patients,the complete trust that they can place their lives or the lives of their loved ones in our care."(Sir William H.Ogilvie,Surgeon)

"The moral obligation to perform all human experiments only after due regard to the sensibility,welfare and safety of the subject must never be violated."(Dr.S.S.Ketty) (p.21)

EXPERIMENTATION - in the loose and strict sense:"Every act of a doctor designed soundly to relieve or cure a given patient is experimentation of an easily justifiable kind. The patient's placement of himself in the doctor's hands is evidence of consent. The problem becomes a knotty one when the acts of the physician are directed not toward the benefit of the patient present but towards patients in general. Such action requires the explicit consent of the <u>informed</u> patient. It also requires more than this;it requires profound thought and consideration on the part of the physician,for the complexities of medicine are in some cases so great it is not reasonable to expect that the patient can be adequately informed as to the full implications of what his consent means. His trust in the physician may lead him too easily to say 'yes'."(Dr.Beecher)

"We should,I think,for present purposes,regard anything done to the patient which is not generally accepted as being for his direct therapeutic benefit or as contributing to the diagnosis of his disease, as constituting an experiment,and falling therefore within the scope of the term'experimental medicine'.((Prof.McCance-Prof.of Exptl.Med.)

[illegible] extensive." (p.22-23)

PHYSICIAN- FRIEND:"One human being is in distress,in need,crying for help;and another human being is concerned and wants to assist him. The cry for help and the desire to render it precipitate their relationship. Theirs is the relationship between two I's,like between two lovers, friends,pupil and teacher. I have called such a relationship 'the mutual obligation of two equals.'

PHYSICIAN-INVESTIGATOR:"The physician-patient relationship of one who performs experiments of no immediate value to the person under observation is impersonal and objective because of the character of the research. Experimentation is the only basis on which they meet. But even though he is the subject in the grammatical sense,he is not the subject in the real personal sense. Every effort is made to depersonalize him and to eliminate every subjective factor. Invoked by the drive for generalization and specialization, objectivity is the password throughout." (Dr.Guttentag) (p.24)

RISK TO THE PATIENT:With but few exceptions,all experiments are a voyage into the unknown,and thus they must carry some risk of the untoward happening. The informed patient who accepts that risk is gambling,but an important feature of that gamble is that the patient has personally something to gain if the experiment is directly concerned with the relief of his symptoms. But the position is entirely different if there is no likelihood of the patient himself benefitting.

Notice that what may appear relatively innocous to the hardened experimentor can produce extreme distress,including a good deal of fear,in a patient who is being subjected to something he does not understand properly. Such distress,endured by the subjects of experiments,is rarely recorded in medical publications and often appears to be of small concern to the experimentors who have caused it. (E.g.Massive haemorraging caused by the accidental piercing of the spleen,kidney or liver,causing severe physical and mental distress to the patient,may be recorded as a trivial accident immediately corrected by blood transfusion.) (p.25-26)

Even a technique which can be employed safely in the hands of a skilled expert should not be used for experimental purposes. E.g."Needle biopsy of the liver should be regarded as potentially fatal. Five hundred biopsies may be performed without incident,only the five hundred and first to be complicated by massive intraperitoneal haemorrage demanding immediate treatment. The patients must therefore be carefully selected and a real indication for it must be present before a biopsy is performed." (Dr.Sherlock,a noted medical researcher) But what is a 'real indication'? Can an experiment the possible findings of which can be of no possible use in the treatment of the patient be said to be based on a 'real indication'? This is the core of the matter.

There is one further point regarding risks and rights of the patient and those of the doctor. Though not everyone will agree,the view should be heard that even a willing and informed patient may not be morally justified in accepting certain risks. It can be maintained that everyone has a certain moral obligation not to run undue risks with his own health or life. "The patient,then,has no right to involve his physical or psychic integrity in medical experiment or research when they entail serious destruction,mutilation,wounds or perils."(Pope Pius XII,Sept.1952,to International Medical Congress) (p.41)

THE PRINCIPLE OF MEDICAL MORALITY:Many experiments are defended by those carrying them out on grounds that while admittedly of no help to the patient or other person who is the subject,the aim of such experiments,is ultimately to help mankind. My contention is that it is immoral to perform experiments,especially dangerous ones,on unsuspecting patients not suffering from the disease being investigated,solely in the hope of making scientific discoveries. Science is not the ultimate good, and the pursuit of new scientific knowledge should not be allowed to take precedence over moral values where the two are in conflict. The statement which is not uncommonly heard among research workers,'It would be interesting to know',though natural and,doubtless,frequently true,is

Dr. Guttentag defined as 'experiments in medicine' "experiments on the sick which are of no immediate value to them, but which are made to confirm or dispute some doubtful or suggestive biological generalization. Recently this type of experiment has become more and more extensive." (p.22-23)

VERSUS

PHYSICIAN-FRIEND: "One human being is in distress, in need, crying for help; and another human being is concerned and wants to assist him. The cry for help and the desire to render it precipitate their relationship. Theirs is the relationship between two I's, like between two lovers, friends, pupil and teacher. I have called such a relationship 'the mutual obligation of two equals'.

not in itself a justification for making experiments of whatever kind. The welfare of the subject must also and always be taken into account.

Any human being has the right to be treated with a certain decency; this right, which is individual, supercedes every consideration of what may benefit science or contribute to the public welfare. No physician is justified in placing science or public welfare first and his obligation to the individual, who is his patient or subject, second.

[illegible] consideration of what

may benefit science or contribute to the public welfare. No physician is justified in placing science or public welfare first and his obligation to the individual, who is his patient or subject, second. No doctor, however great his capacity or original his ideas, has the right to choose martyrs for science or for the common good. As Claude Bernard the founder of modern experimental medicine put it:"The principle of medical morality consists then in never performing on man an experiment which could be harmful to him in any degree whatsoever though the result may be of great interest to science, that is, of benefit to save the health of others." The BRITISH MEDICAL JOURNAL(1962,2,1108) in an editorial wrote:'Hundreds and hundreds of experiments have been conducted which conflict with the principles of medical morality or medical ethics, as enunciated by the founder of experimental medicine." (p.42-43)

"One cannot justify any and every act in the name of the common good and therefore not every use of human beings in research can be justified in the broad notion that in the end others will benefit from such experiments. We must approach the concept of the greater good with our other three affirmations always in mind: that we must protect life, that health is better than sickness, and that we treat individuals as persons and not simply as means." (S.E.Stumpf, Dept.of Philosophy, Vanderbilt Univ., Nashville) An American physician has stated the matter even more strongly: "Any classification of human experimentation as 'for the good of society' is to be viewed with distaste, even alarm. Undoubtedly, all sound work has this as its ultimate aim, but such high-flown expressions are not necessary, and have been used within living memory as cover for outrageous ends." (Dr.H.K.Beecher)

ETHICAL PRINCIPLES: Morality rests on what is right in itself towards the individual immediately involved, not on justification by result, even though that may possibly benefit a great many others. "An experiment is ethical or not at its inception. It does not become ethical post hoc - ends do not justify means. There is no ethical distinction between ends and means. (Dr. H.K. Beecher) (p. 225)

A detailed account of most of the revolting experiments carried out by criminal doctors(convicted at the Nuremberg Trial) has been recorded by Mitscherlich and Mielke, and it is apparent that nothing of medical value was discovered. But I hope that all readers will agree that even if something of value had been achieved it would not even have begun to justify the vileness of what was done. No new scientific truth could have weighed in the balance against the suffering caused. Yet these professors claimed that they did not aim to cause suffering - that could be left to others - but that their aim was to serve medical science. Their guilt was that they ignored the suffering they caused in following this aim and that they persisted in practices which they knew were certain to cause suffering. And this ... is not in principle different from an experimenting doctor in a hospital in Britain or America, ignoring the suffering which he causes and persisting in experiments which he knows will cause suffering, especially when the sufferer has not volunteered for the procedure, but is subjected to it at the sole decision of the doctor (p. 226)

A CODE CONCERNING HUMAN EXPERIMENTATION would be concerned with the following principles:

1. The principle of equality: No experiments should be contemplated, proposed or undertaken to which, if he were in circumstances identical to those of the intended subjects, the experimenter would even hesitate to submit himself or members of his own family, or anybody for whom he had any respect or affection. The idea that the experimenter is worth more than the subject is ruinous. (p. 230)

... 4

[illegible], most patients will consent to any proposals that are made. Further, the considerations involved are so technical as to prevent their being adequately understood by one who is not himself an expert. Two essential pieces of information are often deliberately withheld from the 'consenting volunteers', namely that the procedure is experimental and that its consequences are unpredictable. Moreover, in keeping a subject in the dark as to what is being done to him so as to avoid a refusal, the experimenter is, in fact, guilty of a fraud. (p. 232)

3. <u>The principle of prohibited subjects</u>: Experiments should under no circumstances be performed on mentally sick patients, whatever may be the technical designation of their particular illness. Nor should experiments ever be performed on the aged or the dying. This follows from taking the above two principles seriously. (Especially with regard to the dying and the testing out of new drugs, where the patient cannot be saved it is common humanity that he should be allowed to die in peace.) (p. 235)

4. The principle of previous animal experimentation: This is suggested by every code. (p. 238)

5. The principle of the experimenter's competence: The parts played by people who are actually unqualified medically should be limited.(p.2) to what they can do with complete safety. (p. 240)

6. The principle of proper records: If a patient consents to be subject of an experiment, what has been done to him is virtually part of his medical history. Neglect of proper records is thus against a patient's interests, against those of the doctors and against the interests of medicine.

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In all the above, I am opposed to inhuman clinical research and plead for its replacement by humane research. (Notice how, when speaking of 'mishaps', experimental physicians relate the mishaps to themselves and not the patients.) Every human being has the right to be treated with decency, and that right belongs to each and every individual and should supercede every consideration of what <u>may</u> benefit mankind, what may contribute to public welfare, what <u>may</u> advance medical science. No doctor is justified in placing science or the public welfare first and his obligation to his patient second. Any claim to act for the good of society should be regarded with extreme distaste and even alarm, as it may be a high-flown expression to cloak outrageous acts. A worthy end does not justify unworthy means.

(ibid, suppl.)

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2. <u>The principle of valid consent</u>: (see first five clauses of Nuremberg Code) To obtain the consent of the patient to a proposed investigation is not in itself enough. Owing to the special relationship of trust which exists between a p patient and his doctor, most patients will consent to any proposals that are made. Further the considerations .....(see text)

ON DEATH AND DYING

1. The Doctor face to face with death : Death is a frightful, fearful happening, which, we are convinced, "happens to other people", (Franceis Mauriac). Yet it is something the doctor has to face routinely in the course of his practice. He must face not only the dying patient but also his relatives to whom he has to break the news of the impending end. The patient expects his doctor to stand by him till the end, and in an existential way will ask the doctor about the odds for his life or demise. And, inescapably, the queries of the patient will become the question the doctor must ask himself: 'what is death'? If death is a big problem in the life of the doctor himself, if it is viewed as a frightening, horrible, taboo topic, he will never be able to face it helpfully with his patients. He might hope they will not bring it up, and would probably talk about other trivial things.

The Physician stands always on the side of life. He must wage the battle against death with all the strength of his competence and commitment. He must inspire in his patient the will to live and encourage the hope of recovering health. But if to live is to be free, then the highest point of personal freedom is the courage to face peacefully the prospect of imminent death. If the doctor considers the patient's death as the enemy to his profession, death as a professional battle lost, then in his desperate struggle against death he will not help the patient to serenity and balance, strength and effective personal freedom in the face of death. As a famous physician writes: "Not only for the dying patient but also for the doctor, does a strong faith generate an intensification of freedom. It allows the physician a full commitment to life without that obsession which considers death as the greatest of evils, since we consider death as belonging to the fulness of life. The free acceptance of death is the only real chance to get out of that death which seems to destroy all our strength, a last opportunity to assert our freedom." It should therefore be the doctor's endeavour to assist the patient in achieving a peaceful death. Pain should be relieved as much as possible, but with the main objective of ensuring freedom and peace. The fear of death, it's greatest terror, should be defeated. Only then can freedom mature.

2. The Meaning of Death : In acquiring correct attitudes, the doctor must ask himself, and answer satisfactorily, the question: "What is the meaning of death?" Below are given a few points as guidelines.

   (a) Death is something which happens to a person. Whereas death can be considered from different angles - cytological, physiological, philosophical, theological - each person apprehends his/her death as an uniquely expressive event. It is not 'a machine coming to a stop', nor 'a bit more troublesome form of human waste' nor 'an affront to our inalienable right to life, liberty and the pursuit of happiness' (Toynbee), but an intensely personal thing - a stage in living. The process of dying is in reality the art of living meaningfully in and through the process of dying. "Death belongs to life as birth does; the walk is in the raising of the foot as in the laying it down." (Tagore).

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(b) Death is a real factor in the meaningfulness of life. In the face of death, says Viktor Frankl, as absolute finis to our future and boundary to our possibilities, we are under the imperative of utilizing our lifetimes to the utmost, not letting the singular opportunities - whose 'finite' sum constitutes the whole of life - pass by unused.

(c) Death, for the believer, is also a significant religious event : It is, as it were, the occasion on which we ratify the fundamental options we make in life. Those who, for example, believe in Jesus Christ, and in his passion, death and resurrection, as a salvific event, gain a new vision of death. Christ transforms death into the greatest manifestation of trust in the Father and love for all mankind. For the Christian, death opens on to life eternal. Every doctor should try to be cognizant of the hope and faith of his believing patients, the better to help them to face the prospect of death with equanimity.

3. The Moment of Death : In view of organ transplantation, this question has acquired special significance. After all, a person dying is still a person living, and he keeps his elimentary human rights up to the moment when life becomes extinct.

In short, the principle that brain death is synonymous with the death of the patient (or death of the person) has found universal agreement. A Harvard University team that studied this question in depth gave the following criteria: "It stated that in order for brain death to be designated the subject should be in deep and irreversible coma; manifest a total un-awareness to external painful stimuli; have no spontaneous muscular movements or responses to external stimuli; have no respirations when not in resuscitator; have no elicitable reflexes; have pupils fixed, dilated, and unresponsive to light; and have an isollectric EEG (flat EEG), with the foregoing characteristics having been maintained over a period of 24 hours." (Archives of Internal Medicine, 124 - August 1969 - p. 226-227)

4. THE PROBLEM OF THE PROLONGATION OF LIFE AND EUTHANASIA.

The right to live humanly implies the right to die humanly , i.e. with dignity and in freedom. Does this mean that the patient has the right to end his life or the doctor to assist him in doing so? In a recent document, the American Hospital Association approved a 12-point Declaration of Rights of Hospital Patients, which grants to the patient the right, among others, "to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of his action". This implies that an adult patient with no prognosis for recovery has a right to die without medical therapy. The point is: would this "right to die" justify the patient in asking the doctor to end his life, or justify the doctor in presuming this consent and acting in such a way as to cause death ?

THREE POSSIBILITIES : In the management of terminally ill patients, or patients whose brain has suffered massive destruction to the extent of being irremediably non-functioning, there are three major options :

(1) withdrawal of artificial and/or mechanical life-support systems (i.e. non-interference with death);

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(2) administration of pain-relieving drugs which will have the effect, among other effects, of accelerating the death process (i.e. hastening of death)

(3) administration of death-inducing or life-terminating agents (i.e. deliberate action calculated to cause death).

I think it is arguable, says L. Harmon Smith (ETHICS AND THE NEW MEDICINE, p. 167) that options 1 and 2 are now morally licit procedures in the management of terminal or brain-destroyed patients, but that option 3 is not needed if we properly understand and apply the dispensability (i.e. the non-manditorinees) of both extraordinary and ordinary means which are not remedies. The line between options 2 and 3 is a fine one, I know; but it is reinforced by the awareness that medical science and technology have developed many possibilities for which we have not yet developed the ethical wisdom and moral stamina necessary for exercising humanely responsible control.

SOME NORMS : In arriving at a morally discriminating decision, the following norms should be kept in mind.

(1) "A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

(2) Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community; its members are not bound to prolong the agony for a human being.

(3) There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available. In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances."

(4) "I would urge that we promote the idea of benemori, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. 'Bene mori' that is, allowing the patient to die peaceably and in dignity is always justified."

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EUTHANASIA : Etymologically the word means "dying well". But the word has now come to mean "easy dying", for it implies medical intervention to cut short life by causing death. We must distinguish between euthanasia which is claimed as a legal right, and euthanasia as a moral option.

(a) Legal euthanasia: Advocates of euthanasia as a legal right of every citizen can be understood to speak of euthanasia in two senses:

(i) In the strict sense : i.e., "to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death".

(ii) In a wider sense : This would include: (a) to cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.; (b) to cause death, for the sake of society, to a socially dangerous person, and in general to persons who cannot live morally useful lives within society (the so-called 'eugenic deaths', and disposal of useless persons e.g. the aged, mentally retarded etc.)

The judgement on this has been succinctly formulated by Pope Paul VI when he wrote to the International Federation of Catholic Medical Associations: "Without the consent of the person, euthanasia is murder. His consent would make it suicide."

(b) Euthanasia as a moral option : Here it is customary to distinguish between (i) Direct or positive euthanasia: i.e. the rendering of assistance in order to cause death, This can never be allowed. (ii) Indirect or negative euthanasia: i.e. the administration of treatment, e.g. for the alleviation of pain, which has as a side effect the acceleration of death. Here, we could also include the stopping of those procedures which only prolong the process of dying, while they hold out no hope for life. This should better not be called euthanasia at all, and in fact is morally licit.

FINAL SUMMARY

We can summarize all that has been said above, in an organized way, by quoting extensively from a lecture given by Dr. G.B. Giertz at a Ciba Foundation Symposium on ETHICS IN MEDICAL PROGRESS: with special reference to transplantation. He writes: "The subject of euthanasia poses new problems in medical ethics. The central point is whether we can establish the moment when life ceases to have any human value; this is essentially the same central problem as in abortion, although it is then a question of deciding the time when life begins to have human value. Both problems force us to face up to the question of whether man can draw such a boundary that he can disregard the obligation to protect life. There are essentially two possibilities. One is to leave the duty to protect and preserve human life unconditional. Such a view implies that man lacks the

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right to determine the length of life and to judge what is a valueless life and what a valuable one. The second possibility is euthanasia, for which there are strong advocates in Sweden. A professor of practical philosopy asks: "Is the physician's virtuous skill in repairing damaged individuals and sending them back to so-called life, blind or deaf, with grave changes in personality, with poor sight or deprived of the power of locomotion, actually a gain from the aspect of the value of human life"? In this connexion the economic factor has been mentioned. Is it in fact intended that we shall provide the medical services with resources for furnishing life supporting measures for every individual who might qualify for it, even when the prospects of securing a recovery are negligible? Should we not accept that man shall decide what is fit for life and what is not, and direct our resources to the former?

More recently a third factor has entered this discussion, namely the question of the dignity of life and death. My own attitude is that in the treatment of the hopeless case we should try to act so that the patient, in spite of everything, can live as normal a life as possible and is freed from pain as far as possible. Much of our medical effort is concerned with achieving these ends. We choose the path that appears to us to be the wisest from the human and medical aspects, and thus do not limit our consideration to probable survival time. But when shall we give up the struggle? In most cases it is not difficult to decide. So long as we are not convinced that all hope is gone we should as a rule fight with all the means at our disposal. But when we have been able to establish that the end must soon come, then we should take this into account in our action. In this situation death is a natural phenomenon and should be allowed to run its course. The thought that we physicians should be obliged, for instance, to keep a patient alive with a respirator when there is no possibility of recovery, solely to try to prolong his life by perhaps 24 hours, is a terrifying one. It must be regarded as a medical axiom that one should not be obliged in every situation to use all means to prolong life. Such an obligation would rapidly lead to an untenable situation and spell disaster to our hospital organization. The point is that these considerations are purely medical ones - no step is taken with the object of killing the patient. We refrain from treatment because it does not serve any purpose, because it is not in the patient's interest. I cannot regard this as killing by medical means: death has already won, despite the fight we have put up, and we must accept the fact. Only the recognition of this limit can enable us to solve the problem that for many has made the thought of death an agonizing one - the fear of an artificial prolongation of life when it has already been bereft of all its potentialities.

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TELLING THE TRUTH TO THE PATIENT

> " Death belongs to life as birth does.
> The walk is in the raising of the foot as in the laying it down."
> (Tagore: STRAY BIRDS, CCLXVII)

Death is not only an essential character of human life, it is also a real factor in its meaningfulness. A doctor's duty towards human life includes his duty to help a man to die in peace and dignity. What is the duty of the doctor in respect of telling the dying patient the truth? Below are some quotations that might help seeing one's responsibility in this regard.

1. " There is no single categorical rule about truth-telling. It all depends on the individual patient, his condition at the time, his temperament and frame of mind. The modern doctor is unwilling to 'lie' to the patient. He feels he serves the patient best by telling the truth. But that blunt phrase might be supplememted by the words of the New Testament about "speaking the truth in love". Speaking the truth "in love" may mean . at times, keeping silent. " (W.L. Sperry: THE ETHICAL BASIS OF MEDICAL PRACTICE, p.122)

2. " I believe the question should not be stated, 'Do I tell my patient?' but should be rephrased as, 'How do I share this knowledge with my patient?' The physician should first examine his own attitude toward malignancy and death so that he is able to talk about such grave matters without undue anxiety. He should listen for cues from the patient which enable him to elicit the patient's willingness to face the reality. The more people in the patient's environment who know the diagnosis of a malignancy, the sooner the patient himself will realise the true state of affairs anyway, since few people are actors enough to maintain a believable mask of cheerfulness over a long period of time. Most, if not all, patients know anyway. They sense it by a changed attention, by the new and different approach that people take to them, by the lowering of voices or avoidance of rounds, by a tearful face of a relative or an ominous, smiling member of the family who cannot hide their true feelings. They will pretend not to know when the doctor or relative is unable to talk about their true condition, and they will welcome someone who is willing to talk about it but allows them to keep their defences as long as they have the need for them.

Whether the patien is told explicitly or not, he will nevertheless come to this awareness and may lose confidence in a doctor who either told him a lie or who did not help him face the seriousness of his illness while there might have been time to get his affairs in order.

It is an art to share this painful news with any patient. The simpler it is done, the easier it is usually for a patient who recollects it at a later date, if he can t 'hear it' at the moment.... If the news can be conveyed with the reassurance that everything possible will be done, that they will not be 'dropped', that there are treatments available, that there is a glipse of hope even in the most advanced cases, the patient will continue to have confidence in the doctor, and he will have the time to work through the different reactions which will enable him to cope with this new and stressful life situation." (Dr.E. Kubler-Ross, M.D. : ON DEATH AND DYING, p 32-33)

3. "There is but one Truth of which we are in all circumstances the servants. And what do we find most often about the sick, and with increased intensity as the condition of the patient gets worse? A real conspiracy of lies: pious lies, it is said, though they serve more often the prince of lies than the God of Truth.

What would we say of the duty of truth towards these sick? Is it not the beginning of charity not to deceive? Of course charity excludes neither prudence nor delicacy. But the patient who has always relied on the sincerity of those about him; who, when in health, has never had reason to complain of their truth or of their solicitude - preserves the same attitude of confidence when he becomes a patient. He relies on his own in the hour of danger, and it is in that hour that they conspire to deceive him, to create for him the illusion of a security which no longer exists, and of a hope which is already beginning to fade. The first duty of the doctor is to reveal to those attending the patient and to the patient's relatives the danger and the possibility of a fatal issue. This revelation is not to intensify the conspiracy of silence and of falsehood surrounding the patient, but to seek collaboration in preparing the patient to hear the truth.

Nothing is gained by delay. The more serious the patient's condition becomes, the more difficult it is to tell him.

His friends may find it too difficult to inform the patient, and so they may default. It then becomes possible for the doctor, as his duty demands of him, to act with that simplicity and in that manner which his heart dictates to him.

P.T.O.

If we are really disturbed about the patient's condition, without our hope being shaken, it is best to act before all opportunity is lost. Let us bring this uneasiness of ours clearly to the attention of our patient, rather than dissimulate it under an appearance of reassuring and deceiving joviality. It is not necessary to shout this uneasiness, but we can allow our patient to divine it for himself.

The patient who has noticed our troubled expression as we examine him will question us. Let us not answer immediately, to give the impression that we are hesitating before a truth hard to hear. This deliberate silence will already be, for the still conscious patient, a warning of danger.

If the patient insists , before we leave him, let us admit our concern and specify the deterioration in his condition. This avowal on our part will make his way clear to him. From that moment, his attendants, duly and clearly informed, will create even all unconsciously about the patient this atmosphere of inquietitude favourable∠*warning, which the patient already expects and is ready to meet without surprise and often with gratitude. At the next visit, the patient will watch our expression and, not finding there the relaxing of tension he hoped for, will perhaps demand the truth about his condition. To this request, dictated by his material concerns and by his spiritual, we have no right to answer with a lie. To lie at this moment is to be guilty, more than ever, of betrayal; because the consequences of our lie can be irreparable, both in the material and temporal domain, and in the spiritual domain for eternity.

These rules hold good in other, less dramatic circumstances which contain a sufficient element of uncertainity to justify words calculated to imply a warning. It should be given regularly when a surgical operation, even though not urgent, is indicated and the patient desires to be told clearly how grave the intervention will be, if there is any danger involved. If this is serious and constitutes a risk which is real but indispensible to the conservation of life, our duty is to recognise it without exaggeration. The patient who desires especially to set his material and spiritual house in order, has a right to the truth. The mildest of operations is not exempt from complications and can end by being fatal. Of course, it is not necessary to give these technical details of complications which happily are the exception; but to the question: 'This is not serious, is it, Doctor?' - we can always answer: 'Every operation is a serious matter and must be treated by both doctor and patient as a serious matter. It is best, in every case, to take all necessary material and spiritual precautions. That will be even technically the best psychical preparation for the operation. " (p.94-96)

The tranquil death which we desire for our patients as for ourselves is not necessarily the unconscious death which drugs, even prudently administered, can procure. We seek above all a peaceful death, with the soul at peace and abandoned to goodness and mercy which opens to it the gates of eternal life. The sweetness of death is in that vision of light and of life. "

(Dr. J. Okinczyc , Surgeon and
Professor of the Faculty of Paris
in NEW PROBLEMS IN MEDCIAL ETHICS No. 1 , "Death"

* ∠ to a more formal

EXAMIN-2-ATIONS

4. THE EXAMINATION ITSELF: The first rule is: go to the examination with a well-rested body and brain. If your lack of discretion in studying during the days immediately proceeding the exam has brought about a state of overfatigue, you are likely to be lacking in the necessary agility and clearness of mind at the examination. It is folly to cram in a few more facts at the last moment at the expense of general vigour in all the answers. If such hasty cramming should, by chance, prove helpful in answering this or that question, it produces at the same time muddleheadedness, lassitude and weariness which will certainly affect one's performance as a whole. Keep in mind two rules:

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Ready recall of known (learned) facts; Remember the following:-

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4) RECALL , like assimilation, TAKES TIME. The student's first concern on entering the examination hall should be to make provision for the maximum possible time to be available for the process of recall.

   The maximum time is allowed to the process of revival when an initial period is devoted to planning the answers to the WHOLE of the paper.

   The preliminary preparation of the answers to the whole of the paper sets in motion a process of revival which may still go on (unconsciously) after our thoughts have turned to other things. Figuratively, one might say, whilst the conscious mind is concerned with writing down the answer to one question, the unconscious mind is engaged in preparing the answer to the next.

THE WRITTEN EXAMINATION:

Doing a good paper will imply three steps: thinking, planning and writing. Before writing anything it is good to skim through the whole paper to determine its scope. Read the directions with great care to become aware of the specific type of answer expected.

Frequently, the first reading of an examination paper produces a paralysing effect: either at no finding one's favourite questions there, or simply because the particular association of ideas necessary for the answering of each question have not yet been aroused, and so the paper looks more difficult than it really is. If one keeps calm that feeling will soon vanish. If possible, start with answering the easier questions. This will lessen the tension and help set in motion the associations necessary for the answering of the more difficult ones. In case of the difficult questions make a mental or written summary (if permitted). Fix approximately the time one should devote to each question.

Finally, " write as neatly and as legibly as possible. Teachers have a tendency to overmark neat papers and to under-mark papers that are messy or difficult to read. Before handing in your paper, recheck it entirely; make sure that you have done all that was required and in the way specified." (Conti)

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HOW TO STUDY

1. ORDER AND METHOD: If study is to be productive then it must be orderly and methodical. Method is order in action. Three things are required: a well-planned time-table; a correct combination of study and rest; and, a right approach to the different subjects.

a) Scheduling the time: A time-table is absolutely necessary. It helps make efficeint use of available time; it frees one from both the feeling of hurry and indecision, and, at the same time closes the door on temptations to laziness, unrestrained curiosity and improvisation. Periods of memoriaation and maximum concentration should be short. In general it is better to devote two or three consecutive hours to a single subject (diversified by changes in the method of work - alternating reading with written work) than to attempt to reproduce in private study the routine of school. The time-table should be flexible, especially with reference to internal subdivisions.

b) Periods of study and rest: To keep oneself in good physical, mental and emotional health, one's time-table must be a balanced combination of work and relaxation, of study-time and time for recreation and rest. The normal study period has three phases: (1) the warming-up phase in which initial inertia has to be overcome. (2) the phase of full output, i.e. of relatively high efficiency, during which the learner works at his best. (3) A slowing-down phase that starts with the onset of fatigue and boredom.

According to the curve of efficiency and fatigue the most suitable length of time to be devoted continuously to a subject must be guided by the following consideration: a short period seems inadvisable for it may not allow the second phase to run fully; too lengthy a period may be unprofitable and even harmful due to mounting fatigue and boredom. Study only defeats its own end if continued when fatigue and boredom are caused not by a lack of interest but by a real necessity. Subjective signs of fatigue are nature's warning that a change of occupation or rest is needed. There are emergency forces or energies in man on which he can draw but only at the price of efficiency - if the effort and abuse continue it will result in over-fatigue which reduces the efficiency of work. THEREFORE : Some form of relaxation should be taken for a few minutes in every hour; work should cease for two or three consecutive hours in every day; one complete day of rest and recreation should be reserved in every week; and a holiday of two to three weeks should be taken after several months of work.

c) Right approach to the different subjects: In the first place follow the directions and hints given by the professor or the text book. Each subject demands a method and approach proper to itself. Keep in mind the object of your study as this is identified with one's vocation. The more difficult and essential things should be mastered first, the rest follows easily.

2. GETTING THE MOST OUT OF A STUDY SESSION:

a) Prepare for study: A short prayer to calm the mind, and having ready at hand all the material necessary for study - text book, reference-book, pencils etc. - are indicated.

b) Get straight down to work: Initial inertia will be overcome by working by the rule of your time-table. The problem of concentration is the problem of the "will to work".

c) Be active: and methodical in your activity. Study is personal assimilation. Get an overall view of the entire subject. Read with an inquisitive mind. Try to recall, and reflect on what you've learnt. ("Study for life" - so that you can speak on it)

d) Study calmly: "Above all, let us not hurry, because we have no time to lose." (Dupuytren). Worry is antidoted by action. Anxiety, too. The best results are never secured by feverish energy born of the fear of failure. Build self-confidence by making the most of the powers with which you are endowed, do as well as you can what you can do best. Morever, one should be a little more exacting in one's demand for proof of one's own incompetence. (Incidentally, it should be noted that the proof of the absence of ability is always longer than the proof that it is present. If we once performed a task that is sufficient proof that we can do it.)

e) Protect your solitude: Your room and the set time of study must be considered as sacred. Neither the indiscretion of friends nor a misconceived charity must be allowed to interrupt your work.

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ON EXAMINATIONS

INTRODUCTION: Whoever adopts the rather elegant attitude that he is studying for life and not for exams shows complete ignorance of the educational value of an examination that is well prepared and well done. In all probability, he will not be prepared for either of the two. A real examination obliges us to make a conscientious revision, because we must prepare even those questions which we would never ask ourselves. We thus cover more ground and do it more thoroughly. Often only after an exam does a student feel that he has really begun to know the subject.

1. **PREPARING FOR AN EXAMINATION:** Perhaps the chief advantage of the exam system lies in the incentive it supplies in prescribing that a certain total task should be completed by a definite date. The way to Hell, they say, is paved with vague intentions. The student set to work each day with a well-defined objective - an intermediate goal on the road to his ultimate destination (that of covering the entire syllabus) Preliminary adjustments must be made to maintain appropriate working habits and a constant level of attention throughout the available time. (SEE, what has been said about making a time-table and keeping to it.)

2. **ROUTINE STUDY:** Whereas a student, ideally, desires to learn a set of facts *quickly*, *painlessly* and *once and for all*, he must not expect too much. He must not try to learn them *too* quickly. He cannot expect to learn them *quite* painlessly, and he cannot expect his knowledge to be *absolutely* permanent. He must be prepared to take his time, to take some pains, and he must be prepared to refresh his memory from time to time of the things he already knows.

There are three, and only three, ways in which a fact can be learned: (1) by repetition; (2) by using mnemonic devices; and, (3) by the perception of integrating relations. Each method has its place and distinctive utility. The third method is in general to be preferred. Often it is the quickest, and almost invariably it yields the most stable organization of knowledge. The use of mnemonic devices is not to be despised, and can be usefully employed in subjects like anatomy, provided the system does not become overelaborate.

However, much remains, in every subject, which can only be learned by being repeatedly brought to mind. Such repetitive learning need not be entirely mechanical. In fact, memorization is the more efficient the less purely repetitive it is. Here are three useful principles:

a) Collections of facts may best be memorized in the larger natural systems in which they are found rather than in the smaller artificial sections into which they may be divided. (This is a restatement of the principles of the 'whole' method as opposed to the 'part' method of learning.)

b) Periods of repetition should be relatively brief and well distributed. (In repetitive learning the successive repetitions at any one sitting are subject to a law of diminishing returns. The first reading has greater value than the second, and the second greater value than the third. It follows that the utility of the repetitions is enhanced by augmenting the number of separate sittings and by decreasing the number of readings at each.)

c) Repetitions should alternate with acts of recall. (The most common mistake is to devote relatively too much time to the process of mere reception and relatively too little to the process of assimilation. A safe working rule is to devote at least two units of time to the operation of assimilation to every single unit devoted to reception.)

3. **REVISION:** If it is true that nothing is completely forgotten, it is also true that nothing is wholly free from the ravages of obliviscence. Hence the continuous need for refreshing the mind concerning what is already known. Two broad principlew will guide the student:

(i) Methods of routine study must be designed to facilitate revision.
(ii) Revision should not be deferred until a later stage in the process of preparation for the examinations, but should be distributed throughout the whole course of study.

In general, the methods of taking or recording notes which are best for the main purposes of study are also those that are best adapted for effective revision. Good notes are those that reduce the presented material to *a well-ordered* statements of essentials. Have an over-all picture of the authors argument and then try to fit in the various parts. To resort to hasty cramming just before a test is detrimental to the acquistion of a lasting knowledge, and, besides, it can open the way to nervousness which does not help at examination time.

Topics dealt with in the present course of Medical Ethics

I. INTRODUCTORY LECTURES:

1. What is Medical Ethics? (vs. medical etiquette)
   Basic principles of Medical Ethics.
2. The Concept of Health - a total perspective.
3. Health care priorities and social justice.
4. The Doctor -patient relationship
   - medical responsibility to the individual and community.
   - the doctor vis-a-vis social legislation
   - the medical secret.

II. PROBLEMS CONNECTED WITH THE BEGINNING OF LIFE

5. Artificial Insemination
6. Genetic engineering
7. Abortion

III. PROBLEMS CONNECTED WITH SEXUALITY AND MARRIAGE

8. Meaning of human sexuality
9. Contraception
   a) Motives and methods
   b) Morality
10. Abnormal~~ity~~ sexuality (e.g. homosexuality)
11. Masturbation
12. Marriage counselling (e.g. VD of patient and obligations to partner; sterility; impotence)

IV. PROBLEMS CONNECTED WITH THE INTEGRITY OF THE BODY AND OF THE PERSON.

13. Mutilitation, sterilisation
14. Psychosurgery, psychotherapy, narcoanalysis and hypnotism.
15. Experimentation on human beings

V. PROBLEMS CONNECTED WITH THE END OF LIFE.

16. The meaning of Death
17. Telling the truth to the patient
18. Prolongation of life and the problem of Euthanasia.

VI. SPECIAL SECTION.

19. Alcoholism and drug addiction
20. Transplantation (Blood transfusion & haemodialysis)

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Methodology
Lesson IV

D. Pereira

O N   E X A M I N A T I O N S

INTRODUCTION: Whoever adopts the rather elegant attitude that he is studying for life and not for exams shows complete ignorance of the educational value of an examination that is well prepared and well done. In all probability, he will not be prepared for either of the two. A real examination obliges us to make a conscientious revision, because we must prepare even those questions which we would never ask ourselves. We thus cover more ground and do it more thoroughly. Often only after an exam does a student feel that he has really begun to know the subject.

1. **PREPARING FOR AN EXAMINATION:** Perhaps the chief advantage of the exam system lies in the incentive it supplies in prescribing that a certain total task should be completed by a definite date. The way to Hell, they say, is paved with vague intentions. The student must set to work each day with a well-defined objective - an intermediate goal on the road to his ultimate destination (that of covering the entire syllabus Preliminary adjustments must be made to maintain appropriate working habits and a constant level of attention throughout the available time. (SEE, what has been said about making a time-table and keeping to it.)

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see M+E p57

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4. THE EXAMINATION ITSELF: The first rule is: go to the examination with a well-rested body and brain. If your lack of discretion in studying during the days immediately proceeding the exam has brought about a state of overfatigue, you are likely to be lacking in the necessary agility and clearness of mind at the examination. It is folly to cram in a few more facts at the last moment at the expense of general vigour in all the answers. If such hasty cramming should, by chance, prove helpful in answering this or that question, it produces at the same time muddle-headedness, lassitude and weariness which will certainly affect one's performance as a whole. Keep in mind two rules:

1) Get a good night's sleep before the day of the examination.
2) The deliberate cultivation of a slightly elated, but prevailingly cool and collected,frame of mind offers the best conditions for successful performance in examinations. Flurry and examination nerves may inhibit the more skilled operations of the mind. (Do remember to trust your mind and memory - they are delicately balanced)

Ready recall of known (learned) facts; Remember the following:-

1) Recall of what is known may be inhibited by fatigue.
2) Recall is also adversely affected by the inhibiting emotions - fear, anxiety. (Cultivate coolness!)
3) Recall is blocked by a type of over-concentration of attention and consequent restriction to the free play of the mind over the total field of relevant information.
4) RECALL , like assimilation, TAKES TIME. The student's first concern on entering the examination hall should be to make provision for the maximum possible time to be available for the process of recall.

   The maximum time is allowed to the process of revival when an initial period is devoted to planning the answers to the WHOLE of the paper.

   The preliminary preparation of the answers to the whole of the paper sets in motion a process of revival which may still go on (unconsciously) after our thoughts have turned to other things. Figuratively, one might say, whilst the conscious mind is concerned with writing down the answer to one question, the unconscious mind is engaged in preparing the answer to the next.

THE WRITTEN EXAMINATION:

Doing a good paper will imply three steps: thinking, planning and writing. Before writing anything it is good to skim through the whole paper to determine its scope. Read the directions with great care to become aware of the specific type of answer expected.

Frequently, the first reading of an examination paper produces a paralysing effect: either at not finding one's favourite questions there, or simply because the particular association of ideas necessary for the answering of each question has not yet been aroused, and so the paper looks more difficult than it really is. If one keeps calm that feeling will soon vanish. If possible, start ~~with~~ answering the easier questions. This will lessen the tension and help set in motion the associations necessary for the answering of the more difficult ones. In case of the difficult questions make a mental or written summary (if permitted). Fix approximately the time one should devote to each question.

Finally, " write as neatly and as legibly as possible. Teachers have a tendency to overmark neat papers and to under-mark papers that are messy or difficult to read. Before handing in your paper, recheck it entirely; make sure that you have done all that was required and in the way specified." (Centi) (Story of ABSC IV. & illegible paper!)

THE ORAL EXAMINATION: Take care to understand the specific point asked by the examiner. The exposition and answers must likewise be precise and to the point. Generalities and vague observations make a poor impression. Lifeless slowness must be avoided, but also precipitation which only causes confusion.

Finally, do not suspect your examiner. The examination is not a duel but a species of co-operation. "The examiner is not concerned to expose the bottomless pits of ignorance in the student's mind (however much he may suspect them to be there). He is interested in the little hills of erudition which also diversify the scenery of an otherwise even plain. In this he relies on the student to help him.. by drawing attention with a a measure of pardonable pride to the presence of the little hills." ([illegible])

LECTURE II: Elements of a 'Theistic Philosophy of Life' - Th. Existentialism

1. MAN IS FREEDOM: Man is a conscious-free-being ("has intellect and will).

'Consciousness' refers to man's ability to 'recognise' - 'identify' - what he perceives (basis of science) and to 'reflect' on his being-in -the-world-with-others (basis of philosophy).

Consciousness implies freedom.

When you become conscious of your being here in the classroom, together with others you somehow 'distantiate' yourself from all this; you find it all 'before you'. In 'stepping back' you 'free yourself' from this world to which you belong; you 'transcend the world of facts'; you become 'free'.

This 'becoming free' (from the class, yourself, the others implies the ability to 'take a stand' with regard to this 'world-before-you', that is, the ability to 'respond' to accept or reject, to act (to admire a dress, to hate or love a person, to open or close a book).

This'being-conscious-free' constitutes the essence of man: Man is freedom.

Freedom does not mean:

a) freedom from physical force (even in a concentration camp, man can remain truly human i.e. free).
freedom from moral obligation (a doctor doing what he knows to be his duty remains truly human, i.e. free).
c) that you could have done something else too (the mother rescuing her child from fire is truly human, i.e. free in her action, even though she could not have acted otherwise.)

If you would say 'I'll love you for two weeks', you either talk nonsense or you speak of something else than true love. The moment you become deeply aware of the other, of his needs (e.g. like Christ did) you cannot but respond to the other, to his needs. Still, this loving concern remains truly human, i.e. truly free.

2. MAN IS'INCARNATE'FREEDOM: We exercise our freedom necessarily as this or that person (man, woman, teenager, talented etc.) in this or that situation (in Bangalore, 1970, studying at the College, etc.). We can change our situation; we cannot act independently of it. We can change; but we cannot act 'outside history'. Our freedom is 'incarnate': it is the freedom of this particular creature in this particular setting.

At every moment of our lives we are 'what we have become'; someone who can be described, identified, recognised. (And we want to be accepted as what we are; not merely as something abstract; 'fellow-men'. At the same time, however, we rightly refuse to be 'identified', 'classified' as 'that fellow' (consider the painful experience of someone who is caught peeping through a key-hole, in the eyes of others, he is reduced to a "peeping-tom".) We want to be accepted as persons, that is, as one 'who is free'; with an open horizon of possibilities; who is able to free himself even from himself; able to be ever new.

3. MAN'S DESTINY: LOVE AS THE REALISATION OF FREEDOM.

Man is not born to 'have things'(only the one who is a slave of his desires will place his hope on'having things'; a civilisation dominated by material things and by machines leaves man unfulfilled).

Man is not born to 'become something' (only the slave of his ambitions will place his hope on being something, e.g. a big manager; he will discover that just being this or that is meaningless).

Man is born to love, i.e., to free himself from the tyranny of pride and concupiscence in the encounter with the other (man, God); in the acceptance of the other of which the embrace is the expression(having place for the other which is not the same as 'having use for the other').

To be truly human means: to be 'at-the-world' (recognition of the world as 'object for action') in 'being-with-the-other' (acceptance of the other as person). It means: to become of the true reality and to respond in truth, free from distorting slavery of pride and concupiscence. It means: to encounter the other; entering into an 'I-Thou' relationship; creating the 'we' (in family, church, factory, etc.) building up the **Kingdom** of God: the Kingdom of love; the true society of men.

4. THE EMERGENCE OF GOD. The universe, which finds its fulfillment in man, reveals God; the mystery of Being. Bringing in God as an answer to a problem (e.g. to explain evolution, or cell process) is constructing an 'idol'. "It is impossible to seek God, to love God except through the medium of our fellow men, and hence I cannot realise myself except thru' this same medium."

PHILOSOPHY AND SCIENCE - TWO BRANCHES OF KNOWLEDGE

Does science have all the answers? Can science give all the answers to the problems that a man faces, or to the questions he is constantly putting to himself? As persons committed to the scientific outlook, it is good to place it in its proper perspective, and be conscious of its limits.

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1. Any moral judgement implies knowledge of facts (scientific knowledge) and an insight into values (a philosophic intuition).

To know his duty, a doctor evidently needs knowledge of facts. He needs to know what is the matter with the patient ("what is going on there"), how his condition can be influenced, improved. In order to know what is right and wrong, he even needs to know what consequences his action may have for others, for the medical profession, for society, etc. To form a moral judgement, the doctor needs information that only science can give.

However, even the most complete scientific study of all the facts that are relevant to the case leaves the ethical question still unanswered. The sciences, in describing facts, tell us about the possibilities open to man. A moral judgement, however, deals with the duty of man. It deals with the question as to whether man has any definite task in this world of possibilities. Is there anything to be done, to be realised in this world as described by the scientist? Is there any purpose in man's being in this world? What is man 'meant' to be? Has existence any meaning? What is man? Any moral judgement implies an answer to these questions?

2. The question of the meaning of man is a basic question today. It is the basic question of philosophy.

A. There are 'philosophers' (positivists, upholders of scientism) who reject the very question itself. They believe that asking for the meaning of life is itself "meaningless". For them, all real knowledge can be reduced to science i.e. to empirical, observational, knowledge. What goes as philosophy, they say, is either camouflaged science, poor poetry, or just plain nonsense. Hence, they have only a place for science, and science can only speak of facts, of possibilities, of 'usefulness". (NOTE: One can understand the dilemma with which they are faced. Thus, Bertrand Russell admitted that he had never been able to resolve the problem of how to integrate into his philosophy the great moral sentiments which he felt.)

B. Other philosophers (the Existentialists) recognise the meaningfulness of the question. They believe in philosophy. Science and philosophy, they realise, are two different ways of approaching reality.

Though philosophy and science are both efforts to know and understand the world in which we find ourselves, the philosophical approach (method, attitude) differs basically from the scientific approach.

Science is observational. The scientist deals with observable facts concerning man and the world in which he lives. His approach is that of the onlooker, the observer. In describing the 'nature of things' he actually describes what he 'finds to be the case', 'what is happening there', 'what may be expected to happen in this or that situation'.

Philosophy is reflective. It is man's reflection on his own being, his being conscious - free, his being in the world, his being with others. His reflection is a search for the meaning of human existence, for the true nature of man, for the values to be realised in man's actions and attitudes. His question is not: what is going on there? how explain these facts? BUT: what does it mean to exist through and in these facts? What is man? What does it mean 'to be human'? What does it mean 'to be'.

TWO SCHOOLS OF EXISTENTIALISTS:

a) Questioning the meaning of life, some existentialists (Sartre) conclude that life has no meaning. Though there is much that can be done, there is nothing that should be done. Our being free has no purpose, no meaning. 'Living meaningfully' can only mean: to live according to what you are, that is: free! ("Remain free", " exercise your freedom, redeemed from the slavery of established traditions and convictions, rejecting the 'masks' society holds out to you."). To them 'living meaningfully' means: being oneself. Any committment should be a free choice. (One can understand why life is meaningless, an absurdity - because this life, society, laws, God, impose so many curbs on our freedom i.e the absolute freedom the existentialist dreams of.)

b) Other existentialists recognise that life has a meaning. Man's being free is meaningful. There is something to be done. There is a task which makes 'being-free' meaningful.

QUESTIONS: Can science answer the fundamental questions on man, his nature, the meaning of life, God, creation, destiny? Can we expect it to?

ARTIFICIAL INSEMINATION

INTRODUCTION: The history of medicine offers many instances of medical procedures which were considered medical curiosities, but which become relatively safe and even recommended procedures for the alleviation of some human debility or disease. Artificial insemination is one of them. The ethical question is whether it is lawful or not, or better, whether we have the wisdom, to exercise intentional and purposive control over the generation of life. In simple language, can we say: artificial insemination is a medical possibility, therefore I can do it?

DEFINITION: Artificial insemination(AI) is a procedure which consists of depositing semen, with the aid of instruments, in the vagina, cervical canal, or uterus, with the intention of causing pregnancy, which by ordinary sexual union, is deemed unlikely or impossible.

AI is basically of two types: homologous, when semen is obtained from the husband (AIH); and heterologous, when the semen is secured from a donor (AID). When spermatozoa of the husband are confused or combined with a donor's seminal plasma (for greater sperm motility) the procedure is still called AIH. There is also AIHD or CAI (combined Art. Ins.) when the husband's and donor's spermatozoa are combined - this is done more for emotional than biological reasons.

The common conditions underlying the election of one or other types of AI include impotency or sterility of the husband, genital debility or malformation in either spouse, dyspareunia (ie.difficulty or pain in intercourse) genetic incompatibility (Rh factor)or hereditary disease.

REASONS PUT FORWARD: In the case of AIH, the reason is that the couple want to have a child of their own, if they can. In the case of AID: it provides an acceptable alternative to childlessness in cases of a husband's sterility; that it allows a couple to have a baby "at least half ours"; that it gives a wife the satisfactions of maternity; that people can choose the sort of child they want!

MEANING OF HUMAN PARENTHOOD: To arrive at a moral judgement of this complex issue it is good to agree upon the meaning of human parenthood. Human sexuality is not merely a function of bodily metabolism. Human beings both procreate and reproduce, because through human coition two persons wish both to express their mutual love and at least in principle to particularize it through engendering a third person. Persons reproduce other unique, never-to-be repeated persons. Persons incarnate their engendering love. Thus the sexual union of men and women is never a matter of simple reproduction or recreation; it is always an evidence, when it is authentic, of a loving relationship between them. Babies, new beings like themselves, are procreated in the midst of their love for each other.

THE CASE FOR AIH : When one considers the loftiness of the parental vocation as an essentialpart of marriage, and the immense joy of the spouses who for years have desired children and who, through this manipulation, are able to receive their own child in an atmosphere of genuine love, then AIH can be justified.As to the method of obtaining the semen of the husband (whether it be by aspiration from the epididymus or testicles, or by aspiration from the vagina immediately after coition, or by a cervical spoon, or even by 'masturbation') none is morally wrong in principle. Voluntary ejaculation for justified diagnostic aims does not constitute masturbation nor does it induce any ndrome of mastubatory attitudes.

THE CASE FOR AID: Justification for AIH cannot be unilaterally applied to AID. AID separates procreation from love in the measure to which neither donor nor recepient posits his or her act within the sphere of a love which unites them, In AID each functions, as it were, from "outside" the other, thereby putting asunder"what God God joined together" when he made love procreative. However, to speak this way about AID is not to label it adultery, though it is thus considered by many courts of law.

We shall now consider the implications of AID from various points of view - medical, legal, social and philosophical before arriving at a moral judgement on the justification or otherwise of AID. (Incidentally, this discussion must show us how careful we must be before we pass moral judgements, and that in taking a moral decision affecting his patient or a medical procedure, a doctor should not rely on his own medical wisdom, but has need to seek insights from other specialties.)

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a) Medical implications: Several medical conditions are required in the donor. (1) He should be in good health, free from transmittable diseases, venereal or otherwise; (2) he should be studied from the point of view of heredity (malformation, psychoses in forbears or collaterals); (3) it is desirable that he should resemble husband in physical and racial qualities; (4) if possible, his intellectual and moral qualities should be superior or equal to that of husband.

As a purely medical procedure, AID raises serious moral questions. It is well known that AI rarely succeeds the first time, and that it is necessary to repeat the operation over several consecutive months. For this the sperm must be frozen and preserved. Now, are the parents justified in exposing "their" child to unknown hazards because of possible genetic mutation? Would abortion be the justified 'next step', in case of a defective offspring? FURTHER, to consider AID as a step towards "progressive eugenics" is simplistic, to say the least. It has been calculated that through random fertilization there is a possibility of 70 trillion genotypes of offspring, which amounts to 2300 generations of the entire present population of the entire world (figures given by Bentley Glass, SCIENCE AND ETHICAL VALUES quoted in ETHICS AND THE NEW MEDICINE, by Harmon L. Smith, p 87). Consider, further, that of the approximately 500 defects that are suspected to be controlled by the genes, we have more or less effective tests for fewer than 4 percent, and one wonders whether AID, purely from the medical point of view, is going to give us superior individuals of the sort dreamed of in A. Huxley's BRAVE NEW WORLD.

b) Legal implications: In certain countries, AID constitutes adultery, and the offspring is considered illegitimate . Besides, many difficulties arise in the matter of property rights and rights to succession. AID further gives rise to possible falsification of certificates because of the secrecy involved with regard to the anonymity of the donor etc.

c) Social implications: Several psycho-social conditions must be fulfilled in order to avoid unpleasant consequences. These are: (I) The donor must not know who the couple are. (ii) The couple must not know who the donor is. (iii) No third party not bound by the medical secret should be told about the operation. (iv) There must be a certainty about the deep and persistent desire of the couple and the stability of their home.

A number of questions naturally arise. Who decides that the donor is the "ideal" man? On what does he base his judgement? Is he a man of superior moral qualities who for a sum of money calmly enter a doctor's ejaculate semen into a beaker? Who would without a sense of responsibility be a father to a child or children whom he would never see now have a duty towards? Further, what of the social dangers of marrying first-cousins without knowing it?

d) Philosophical implications: Gabriel Marcel, noted French philosopher has characterised the whole procedure of AID by two words : grotesque and burlesque. Another commentator has suggested the same when he says that we could cast a slur at an AID child by calling him a "son of a test-tube". The fact is that AID supporters:

(i) forget that AID is not a simple operation like a blood transfusion; and forgets further that it has psychological overtones for the husband. To the husband the child is a stepchild, a constant reminder of his own sterility. The AID child will have an extreme effect on the marriage itself by signifying achievement of motherhood for the wife and failure of fatherhood for the husband. (In this connection, adoption is a far better solution.)

(ii) deny the value of marriage as love particularized in procreation. The AID child is the fruit of a process not of love.

(iii) base their reasoning on a false philosophy of life: "every man has a right to be happy and therefore to do as he pleases". The view is sometimes put forward that every woman has a right to maternal fulfillment. Why, it has been asked, no one thought of the right of the husband to paternity, and suggested an anonymous #egg and womb" donor to receive his semen in case his wife is sterile?

The point is that, by definition, personal fulfullment cannot be a private affair in the context of love and marriage, nor can it be achieved outside the sharing, involvement and participation of the other. Through love and marriage a man and a woman become husband and wife - and husband and wife thru' mutual love want not a child but "our" child. Paul Ramsey puts it as follows: "Men and women have no unqualified right to have children. It is simply not the business of medical practice to enable every marriage to produce a child by any means." (cfr. LINACRE QUARTERLY, 1971, p. 19)

Moreover, in view of the population explosion and a growing number of homeless and otherwise disadvantaged children, it is at least arguable that AID is socially irresponsible and that adoption, which alleviates the needs of both childless couples and parentless children, offers a preferable alternative to involuntary childlessness. The argument that AID gives the wife the satisfactions of maternity may be countered by the fact that fecundity means more that breeding, and that the serious threat to marital harmony and love caused by the radical asymmetry whereby the wife has achieved motherhood but the husband has failed to achieve fatherhood, should weigh very heavily against AID.

A MORAL JUDGEMENT: (The formulation of this moral judgement is chiefly in the words of Harmon L. Smith in his book ETHICS AND THE NEW MEDICINE p. 83 ff.) For the present, and in view of (1) the way we have understood sex and marriage, (2) what we know about AI, and (3) other social and psychological factors which impinge upon this action, the most responsible (not to say the only) response appears to be a qualified "yes" to AIH and a qualified "no" to AID.

In the case of AIH, there is no moral question of adultery inasmuch as the unitive and procreative dimensions of human sexuality are preserved. Moreover, a child thus conceived and born is in every sense truly the fruit of the union between this husband and wife who are parents both biologically and personally. As for the morality of the methods for securing the husband's semen, none, not even masturbation, is morally wrong in principle.

AID, however cannot be similarly justified. AID separates procreation from love in the measure in which neither donor nor recepient posits his or her act within the sphere of a love which unites them. This is not to say that AID is adultery in the conventional sense, nor even in the sense of carnal lust. But it is lust in the sense of envy or covetousness that best characterizes the moral failure of AID, for it is argued that a woman should not be deprived of the self-fulfillment of maternity just because she loves and is married to a man who happens to be sterile. Further, parenthood is not a natural right and in the light of the population explosion and the growing number of homeless children one can at least argue that AID is socially irresponsible, because adoption would satisfy the needs of parenthood and parentless children at the same time.

Finally, in view of the fact that it is estimated that up to 150,000 living Americans owe their births to AI (TIME, 1966, Feb. 25, p.48) and that about 10000 pregnancies per year are being achieved through AI, one could go with the statement made by the author elsewhere (p. 167) and in another context, that " medical science and technology have developed many possibilities for which we have not yet developed the ethical wisdom and moral stamina necessary for exercising humanely responsible control."

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3. Health care priorities and social justice.
4. The Doctor -patient relationship
   - medical responsibility to the individual and community.
   - the doctor vis-a-vis social legislation
   - the medical secret.

II. PROBLEMS CONNECTED WITH THE BEGINNING OF LIFE

5. Artificial Insemination
6. Genetic engineering
7. Abortion

III. PROBLEMS CONNECTED WITH SEXUALITY AND MARRIAGE

8. Meaning of human sexuality
9. Contraception
   a) Motives and methods
   b) Morality
10. Abnormal~~ity~~ sexuality (e.g. homosexuality)
11. Masturbation
12. Marriage counselling (e.g. VD of patient and obligations to partner; sterility; impotence)

IV. PROBLEMS CONNECTED WITH THE INTEGRITY OF THE BODY AND OF THE PERSON.

13. Mutilitation, sterilisation
14. Psychosurgery, psychotherapy, narcoanalysis and hypnotism.
15. Experimentation on human beings

V. PROBLEMS CONNECTED WITH THE END OF LIFE.

16. The meaning of Death
17. Telling the truth to the patient
18. Prolongation of life and the problem of Euthanasia.

VI. SPECIAL SECTION.

19. Alcoholism and drug addiction
20. Transplantation (Blood transfusion & haemodialysis)

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Duplicate

ON THE MEANING OF LIFE

(Extracts from THE DOCTOR AND THE SOUL by Dr. Viktor Frankl,M.D.

1. Three factors characterize human existence as such: man's spirituality, his freedom, his responsibility. The spirituality of man is a thing-in-itself. It cannot be explained by soemthing not spiritual; it is irreducible. Freedom means freedom in the face of three things: (1) the instincts; (2) inherited disposition; and (3) environment. Thus man is by no means merely a product of heredity and environment. There is a third element: decision. Man ultimately decides for himself. Responsibility - to his conscience and to God.a

If we present man with a concept of man which is not true, we may well corrupt him. When we present man as an automaton of reflexes, as a mind-machine, as a bundle of instincts, as a pawn of drives and reactions, as a mere product of instinct, heredity and environment, we feed the nihilism to which modern man is, in any case, prone. (PP. xviii - xxi passim)

2. Being human is being responsible because it is being free.

The freedom of decision, so-called freedom of the will, is for the unbiased person a matter of course; he has an immediate experience of himself as free. The person who seriously doubts freedom of the will must either be hopelessly prejudiced by a deterministic philosophy or suffering from a paranoid schizophrenia, in which case he experiences his will as having been "made" unfree.... To be human means not only to be different, but also to be able to become different, that is, to change. (p. 77-78) Jaspers calls the eing of man a "deciding" being, not something that simply "is" but something hat first decides "what it is"..The meaning of concepts like those of merit and guilt stands and falls on our belief in man's true capacity for not simply accepting as fated limitations the constraints imposed by race, class or character; on his capacity for seeing them instead as challenges bidding him shape his destiny and life. (p. 21)

3. To ask the meaning of life in general terms is to put the question falsely because it refers vaguely to "life" and not concretely to "each person's own" existence. We must give the question of the meaning of life an entirely new twist. To wit: It is life itself that asks questions of man. In the last resort, man should not ask "What is the meaning of my life?" but should realise that he himself is being questioned. Life is putting its problems to him, and it is up to him to respond to these questions by being responsible; he can only answer to by answering for his life. (p. 61 & xv)

4. Life is a task. The task a man has to accomplish in life is at bottom always present and in principle is always within the man's powers...The individual must comprehend his responsibility to accomplish ch of his tasks. The more he grasps the task quality of life, the more aningful his life will appear to him. While the man who is not conscious of his responsibility simply takes life as a given fact, existential analysis teaches people to see life as an assignment. But the follwomg addendum must be made: There are people who go a step further, who, as it were, experience life in a further dimension. They also experience the authority from which the task comes. They experience the taskmaster who has assigned the task to them. In our opinion we have here an essential characteristic of the religious man: he is a man who interprets his existence not only in terms of being responsible for fulfilling his life tasks, but also as being responsible to the taskmaster. (p. 58-59) The religious man differs from the apparently irreligious man only by experiencing his existence not simply as a task, but as a mission. This means that he is also aware of the taskmaster, the source of his mission. For thousands of years that source has been called God.... Religion provides man with a spiritual anchor, with a feeling of security such as he can find nowhere else.(p. xv)

5. CONCLUSION : " Whoever has a reason for living endures almost any mode of life."(Nietzsche) But if a person should object that he does not know the meaning of life, that the unique potentialities of his existence are not apparent to him, then we can reply that his primary task is just this: to find his way to his own proper task, to advance towards the uniqueness and singularity of his own meaning in life. As for this matter of each man's inner potentialities - in other words, how a man is to go about learning what he ought to be from what he is - there is no better answer than that given by Goethe: " How can we learn to know ourselves? Never by reflection, but by action. Try to do your duty and you will soon find out what you are. But what is your duty? The demands of each day."(p.56)

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KNOWING MYSELF

"TO BE THAT SELF WHICH ONE TRULY IS"

After I returned to prison, I took a long look at myself, and, for the first time in my life, admitted that I was wrong, that I had gone astray ..... from being civilised. For I could not justify my crime. Even though I had some insight into my own motivations, I did not feel justified. I lost my self respect. My pride as a man dissolved and my whole fragile moral structure seemed to collapse, completely shattered. That is why I started to write ..To save myself.

" I realised that no one could me but myself. I learned,too, that I had been taking the easy way out, running away from problems. I also learned that it is easier to do evil than it is to do good. The price of hating other human beings is knowing oneself less. "

- Elridge Cleaver, SOUL ON ICE (p. 15)

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"TO BE THAT SELF WHICH ONE TRULY IS"

- adapted from ON BECOMING A PERSON,
by Carl Rogers

Each individual asks himself: "Who am I? How can I become myself?"

1. He must drop the defensive masks with which he has faced life. He then experiences fully the hidden aspects of himself - the stranger behind the mask, the stranger who is himself.

2. He then becomes more open to all the elements of his organic experience, and develops a trust in his own organism as an instrument of sensitive living. ("Evaluation by others," says Rogers, "is not a guide for me.")

3. He learns to become responsible for himself ("I am the one who chooses .... who determines the value of an experience for me.")

4. He learns to live his life as a participant in a fluid, on-going process in which he is continually discovering new aspects of himself in the flow of his experience.

* * *

PUT IN OTHER WORDS......

" To be that self which one truly is....."

ONE MUST : - move away from facades (from the self one is not)
- move away from "oughts"
- move away from meeting the expectations of others
- move away from pleasing others

ONE MUST MOVE TOWARDS:

* being autonomous - become responsible for oneself
* being a process, a fluidity, a changing (in a flux)
* being a complexity of process ("I can't always understand myself")
* openness to one's own experiences (feelings, emotions)
* acceptance of others
* trust of self

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WHAT IS MAN?

Man is a contradictory being : " a nothingness with a capacity for God"

- Man is conscious-free: open to the beyond; with an infinite striving
- Man is an embodied subject ("Man is a thinking reed" - Pascal)
- Man has his own unique history - and shapes his own destiny
- Man is a subject among subjects ("I discover myself through discovering others"

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PHILOSOPHY AND SCIENCE - TWO BRANCHES OF KNOWLEDGE

Does science have all the answers? Can science give all the answers to the problems that a man faces, or to the questions he is constantly putting to himself? As persons committed to the scientific outlook, it is good to place it in its proper perspective, and be conscious of its limits.

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1. Any moral judgement implies knowledge of facts (scientific knowledge) and an insight into values (a philosophic intuition).

To know his duty, a doctor evidently needs knowledge of facts. He needs to know what is the matter with the patient ("what is going on there"), how his condition can be influenced, improved. In order to know what is right and wrong, he even needs to know what consequences his action may have for others, for the medical profession, for society, etc. To form a moral judgement, the doctor needs information that only science can give.

However, even the most complete scientific study of all the facts that are relevant to the case leaves the ethical question still unanswered. The sciences, in describing facts, tell us about the possibilities open to man. A moral judgement, however, deals with the duty of man. It deals with the question as to whether man has any definite task in this world of possibilities. Is there anything to be done, to be realised in this world as described by the scientist? Is there any purpose in man's being in this world? What is man 'meant' to be? Has existence any meaning? What is man? Any moral judgement implies an answer to these questions?

2. The question of the meaning of man is a basic question today. It is the basic question of philosophy.

A. There are 'philosophers' (positivists, upholders of scientism) who reject the very question itself. They believe that asking for the meaning of life is itself "meaningless". For them, all real knowledge can be reduced to science i.e. to empirical, observational, knowledge. What goes as philosophy, they say, is either camouflaged science, poor poetry, or just plain nonsense. Hence, they have only a place for science, and science can only speak of facts, of possibilities, of 'usefulness". (NOTE: One can understand the dilemma with which they are faced. Thus, Bertrand Russell admitted that he had never been able to resolve the problem of how to integrate into his philosophy the great moral sentiments which he felt.)

B. Other philosophers (the Existentialists) recognise the meaningfulness of the question. They believe in philosophy. Science and philosophy, they realise, are two different ways of approaching reality.

Though philosophy and science are both efforts to know and understand the world in which we find ourselves, the philosophical approach (method, attitude) differs basically from the scientific approach.

Science is observational. The scientist deals with observable facts concerning man and the world in which he lives. His approach is that of the onlooker, the observer. In describing the 'nature of things' he actually describes what he 'finds to be the case', 'what is happening there', 'what may be expected to happen in this or that situation'.

Philosophy is reflective. It is man's reflection on his own being, his being conscious - free, his being in the world, his being with others. His reflection is a search for the meaning of human existence, for the true nature of man, for the values to be realised in man's actions and attitudes. His question is not: what is going on there? how explain these facts? BUT: what does it mean to exist through and in these facts? What is man? What does it mean 'to be human'? What does it mean 'to be'.

TWO SCHOOLS OF EXISTENTIALISTS:

a) Questioning the meaning of life, some existentialists (Sartre) conclude that life has no meaning. Though there is much that can be done, there is nothing that should be done. Our being free has no purpose, no meaning. 'Living meaningfully' can only mean: to live according to what you are, that is: free! ("Remain free", " exercise your freedom, redeemed from the slavery of established traditions and convictions, rejecting the 'masks' society holds out to you."). To them 'living meaningfully' means: being oneself. Any committment should be a free choice. (One can understand why life is meaningless, an absurdity - because this life, society, laws, God, impose so many curbs on our freedom i.e the absolute freedom the existentialist dreams of.)

b) Other existentialists recognise that life has a meaning. Man's being free is meaningful. There is something to be done. There is a task which makes 'being-free' meaningful.

QUESTIONS: Can science answer the fundamental questions on man, his nature, the meaning of life, God, creation, destiny? Can we expect it to?

MEDITATION

FOR THE MINISTRY OF HEALING

FROM THE PARABLE OF THE GOOD SAMARITAN

'A man was going down from Jerusalem to Jericho and he fell among robbers, who stripped him and beat him, and departed, leaving him half dead...'

Let us Pray:

For all who start the day in health but end it in pain,
Hear us, O Lord.

For all who suffer injury at the hands of others,
Hear us, O Lord.

For all who reveal their sickness by placing material things before human values or moral principles,
Hear us, O Lord.

For all who reveal their sickness by being insensitive to the pain and distress of others,
Hear us, O Lord.

And for all who reveal their sickness by brutality and greed,
Hear us, O Lord.

'Now by chance a priest was going down the road; and when he saw him he passed by on the other side. So likewise a Levite, when he came to the place and saw him, passed by on the other side.'

Let us pray:

For all whose lives are dominated by hypocrisy or ignorance,
We pray, Good Lord.

For those who practise their piety only before men to be seen by them,
We pray good Lord.

For those who say 'Lord, Lord' but do not the will of the Father in heaven
We pray, good Lord.

For those who are in need but are neglected because they have no voice to cry for help,
We pray, good Lord.

For those who are in need but are neglected because those who can help avoid responsibility,
We pray, good Lord.

'But a Samaritan, as he journeyed, came to where he was, and when he saw him, he had compassion, and went to him...'

Let us pray:

That we may be blind to race or caste,
Open our minds, O Lord of Truth.

That we may be led to those in need,
We ask your guidance, O Lord, Good Shepherd.

That we may see the needy, wherever they are.
Give us eyes, O Lord our light,
That we may have compassion,
Live in our hearts, O Lord our life.

That we may go to those who need us,
Order our footsteps, O Lord our way.

'And bound up his wounds, pouring on oil and wine, then he set him on his own beast, and brought him to an inn and took care of him....'

1. PRAYER OF A DOCTOR

Thy eternal providence has chosen me
to guard the life and health of thy creatures.
May the love of my art inspire me always.

Do not let my spirit be confused by greed or thirst for fame
and distinction,
For they are the enemies of truth and of love.

They might easily divert me from my great purpose:
to look after thy creatures.

Let me always in the sufferer see the man.

Give me strength, time, and energy
to improve and extend my knowledge.

The field of science is great,
but we do not know the limits of human reason;
it penetrates further and further;
today it discovers many errors in what I yesterday
thought I knew,
and my knowledge of today may tomorrow appear to be
full of defects.
God, thou hast chosen me
to guard the life and death of thy creatures.
Here I am, ready to follow my vocation.

2. PRAYER OF A TEACHER:

Lord God, merciful and patient, grant us grace, we beseech
thee,
ever to teach in a teachable spirit,
learning along with those we teach,
and learning from them whenever thou so pleasest.
Word of God, speak to us, speak by us, what thou wilt.
Wisdom of God, instruct us, instruct by us, if and whom
thou wilt.
Eternal truth, reveal thyself to us, reveal thyself by us,
in whatsoever measure tho wilt;
that we and they may all be taught of God.

Let us pray:

For understanding and skills which are useful for healing, and for those who employ them,

Receive our Thanks, O Lord, Great Physician.

For medicines and salves and drugs, and those who develop and prescribe them,

Receive our thanks, O Lord, Great Physician.

For beasts and carts, for petrol(gasoline) and ambulances, for stretchers and bearers, for drivers and attendants,

Receive our thanks, O Lord, Great Physician.

For homes and hostels, clinics and hospitals, rest houses and shelters of any kind, and for those who welcome strangers in their midst.

Receive our Thanks, O Lord, Great Physician.

For those who attend the sick with loving care, nurses and aides, orderlies and therapists, housekeepers and cooks, physicians and all other healers,

Receive our thanks, O Lord Great Physician.

'And the next day he took out two denarii and gave them to the innkeeper, saying, "Take care of him, and whatever more you spend, I will repay you when I come back!" '

Let us pray:

For all who are concerned for the welfare of others,

We praise Your Name, O God for we can love only because You first loved us.

For all who support the work of the ministry of healing and care throughout the world, through the Churches, through the government, through volunteer groups...

We praise your Name, O God giver of every good and perfect gift.

For all who administer the gifts of others as good managers of your work,

We praise your Name, O Lord, who is the same Yesterday, today, and forever.

For the ability to see, to serve and to share, and thus to become neighbour to those who are in need,

We praise your Name, O Lord, Who not only has commanded, but has enabled us to 'go and do likewise'.

LECTURE II: Elements of a 'Theistic Philosophy of Life' - Th. Existentialism

1. MAN IS FREEDOM: Man is a conscious-free-being ("has intellect and will).

'Consciousness' refers to man's ability to 'recognise' - 'identify' - what he perceives (basis of science) and to 'reflect' on his being-in -the-world-with-others (basis of philosophy).

Consciousness implies freedom.

When you become conscious of your being here in the classroom, together with others you somehow 'distantiate' yourself from all this; you find it all 'before you'. In 'stepping back' you 'free yourself' from this world to which you belong; you 'transcend the world of facts'; you become 'free'.

This 'becoming free' (from the class, yourself, the others implies the ability to 'take a stand' with regard to this 'world-before-you', that is, the ability to 'respond' to accept or reject, to act (to admire a dress, to hate or love a person, to open or close a book).

This'being-conscious-free' constitutes the essence of man: Man is freedom.

Freedom does not mean:

a) freedom from physical force (even in a concentration camp, man can remain truly human i.e. free).
b) freedom from moral obligation (a doctor doing what he knows to be his duty remains truly human, i.e. free).
c) that you could have done something else too (the mother rescuing her child from fire is truly human, i.e. free in her action, even though she could not have acted otherwise.)

If you would say 'I'll love you for two weeks', you either talk nonsense or you speak of something else than true love. The moment you become deeply aware of the other, of his needs (e.g. like Christ did) you cannot but respond to the other, to his needs. Still, this loving concern remains truly human, i.e. truly free.

2. MAN IS'INCARNATE'FREEDOM: We exercise our freedom necessarily as this or that person (man, woman, teenager, talented etc.) in this or that situation (in Bangalore,1970,studying at the College, etc.). We can change our situation; we cannot act independently of it. We can change; but we cannot act 'outside history'. Our freedom is 'incarnate': it is the freedom of this particular creature in this particular setting.

At every moment of our lives we are what we have become'; someone who can be described, identified, recognised. (And we want to be accepted as what we are; not merely as something abstract: 'fellow-men'. At the same time, however, we rightly refuse to be'identified', 'classified' as 'that fellow' (consider the painful experience of someone who is caught peeping through a key-hole, in the eyes of others, he is reduced to a "peeping-tom".) We want to be accepted as persons, that is, as one 'who is free'; with an open horizon of possibilities; who is able to free himself even from himself; able to be ever new.

3. MAN'S DESTINY: LOVE AS THE REALISATION OF FREEDOM.

Man is not born to 'have things'(only the one who is a slave of his desires will place his hope on'having things'; a civilisation dominated by material things and by machines leaves man unfulfilled).

Man is not born to 'become something' (only the slave of his ambitions will place his hope on being something, e.g. a big manager; he will discover that just being this or that is meaningless).

Man is born to love, i.e., to free himself from the tyranny of pride and concupiscence in the encounter with the other (man,God); in the acceptance of the other of which the embrace is the expression(having place for the other which is not the same as 'having use for the other').

To be truly human means: to be 'at-the-world' (recognition of the world as'object for action') in 'being-with-the-other' (acceptance of the other as person). It means: to become of the true reality and to respond in truth,free from distorting slavery of pride and concupiscence. It means: to encounter the other; entering into an 'I-Thou' relationship;creating the 'we' (in family, church,factory,etc.) building up the Kingdom of God:the Kingdom of love; the true society of men.

4. THE EMERGENCE OF GOD. The universe,which finds its fulfillment in man, reveals God;the mystery of Being. Bringing in God as an answer to a problem (e.g.to explain ~~evolution~~,or cell process) is constructing an 'idol'. "It is impossible to seek God, to love God except through the medium of our fellow men, and hence I cannot realise myself except thru' this same medium."

SYMPOSIUM ON MASTURBATION AND HOMOSEXUALITY - Wed. Apr.5,'72

A brief summary of the main points.

A. MASTURBATION:

1. In adolescents: It is a normal manifestation of adolescence

- due to the adolescent's inability to resolve, satisfactorily, the conflict he/she experiences between the demands of the child and that of the adult. It bespeaks lack of control of the emotions & of the will.

In adults:
- may be due to unusual conditions (periodic masturbation)
- sign of un-completed adolescence (tinged with narcissism)
- recurrence in a durable fashion can be
  - (a) due to intellectual weakness (senility, cerebral atrophy, alcoholism)
  - (b) a sign of schizophrenic dissociation.

2. Effects: It is not the cause of physical or mental illness, but it may be a manifestation of psycho-neurotic imbalance. As such, indulgence in mastubatory activity only re-inforces the imbalance. (Dr. Viktor Frankl speaks of a "mastubatory hangover" - a sort of guilt because the act is not "goal-directed")

HOWEVER, masturbation is an act of infantile narcissism, sexual immaturity, and is not altruistic. Thus, it may make interpersonal relationship, especially with the spouse in marriage, difficult.

3. Treatment: Education about true meaning of human sexuality. Education of the will to self-control; inculcating self-confidence; setting high ideals to break ego-centricism.

Masturbation is not always a sin, but is always a disorder. Doctor/counsellor should allay excessive guilt or fears, but should not condone it, much less recommend it.

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B. HOMOSEXUALITY

1. Homosexuality has many causes and is of several types. A distinction should be made between:

Homosexuality: cases of long-standing overt sexual activity with preference for the same sex.

Homophilia: marginal erotic friendship with a member of the sam sex without indecent behaviour.

2. It is not an illness in the strict sense, but a defective functioning that calls for medical and other help.

3. Ethical homosexuality, or homosexuality by choice, is sinful.

Homosexual perversion of the young is also considered a crime.

4. Treatment: There is no REAL treatment, but through sublimation and anamnetic methods some cases of overt homosexuality can be reduced to a latent form. This should be considered a therapeutic success.

- Undue moralism (and labelling a person 'homosexual') can lead to further phobic anxiety. Doctor should help patient to find meaning of human sexuality. While he cannot encourage what is against the principles of morality, he should neither obstruct the process of healthy transformation by unduly insisting on a moralism of principles.

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[illegible] are highlighted which have relevance to the whole field of medicine. Surely it will be very profitable to all doctors and students who read it.)

HUMAN GUINEA PIGS

by Dr.M.H.Pappworth
(Penguin Books)

THE PROBLEM: For several years a few doctors in this country and in America have been trying to bring to the attention of their fellows a disturbing aspect of what have become commonc practices in medical research. These practices concern experiments made chiefly on hospital patients, and the aspect which is disturbing is the ethical one. In their zeal to extend the frontiers of medical knowledge, many clinicians appear temporarily to have lost sight of the fact that the subjects of their experiments are in all cases individuals with common rights, and in most cases sick people hoping to be cured. As a result it has become a common occurrence for the investigator to take risks with patients of which those patients are not fully aware, or not aware at all, and to which they would not consent if they were aware; to subject them to mental and physical distress which is in no way necessitated by, and has no connexion with, the treatment of the disease from which they are suffering; and in some cases deliberately to retard the recovery from that disease so that investigation of a particular condition can be extended. (p.15)

SUMMARY OF VIEWS ON MEDICAL EXPERIMENTATION: 1) Clinical research must go on, but there must be acknowledged and observed safeguards for the patients. At present such safeguards are virtually non-existent. 2) The majority of those engaged in clinical research act with the highest moral integrity, but an expanding minority resort to unethical and probably illegal practices. 3) Unless the medical profession itself stops the unethical practices of this minority, the public outcry will eventually be such as to cause opposition to all clinical research (p. 18)
"It behoves the medical profession to take the public into its confidence. The primary step is to recognise that difficult moral problems - indeed the moral dilemma - do exist for which help and guidance can be sought from many sources. In the end we have to accept the fact that some limits do exist to the search for knowledge."(Prof.P.A.Freund - Lawyer) (p.20)

WHAT CONSTITUTES A JUSTIFIABLE EXPERIMENT? "The science of experimental medicine is something new and sinister; for it is capable of destroying in our minds the old faith that we, the doctors, are the servants of the patients whom we have undertaken to care for, and in the minds of the patients, the complete trust that they can place their lives or the lives of their loved ones in our care."(Sir William H.Ogilvie, Surgeon)
"The moral obligation to perform all human experiments only after due regard to the sensibility, welfare and safety of the subject must never be violated."(Dr.S.S.Ketty) (p.21)

EXPERIMENTATION - in the loose and strict sense: "Every act of a doctor designed soundly to relieve or cure a given patient is experimentation of an easily justifiable kind. The patient's placement of himself in the doctor's hands is evidence of consent. The problem becomes a knotty one when the acts of the physician are directed not toward the benefit of the patient present but towards patients in general. Such action requires the explicit consent of the informed patient. It also requires more than this; it requires profound thought and consideration on the part of the physician, for the complexities of medicine are in some cases so great it is not reasonable to expect that the patient can be adequately informed as to the full implications of what his consent means. His trust in the physician may lead him too easily to say 'yes'."(Dr.Beecher)
"We should, I think, for present purposes, regard anything done to the patient which is not generally accepted as being for his direct therapeutic benefit or as contributing to the diagnosis of his disease, as constituting an experiment, and falling therefore within the scope of the term 'experimental medicine'.((Prof.McCance-Prof.of Exptl.Med.)

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PHYSICIAN-FRIEND:'One human being is in distress, in need, crying for help; and another human being is concerned and wants to assist him. The cry for help and the desire to render it precipitate their relationship. Theirs is the relationship between two I's, like between two lovers, friends, pupil and teacher. I have called such a relationship 'the mutual obligation of two equals.' (p.22-23)

PHYSICIAN-INVESTIGATOR:"The physician-patient relationship of one who performs experiments of no immediate value to the person under observation is impersonal and objective because of the character of the research. Experimentation is the only basis on which they meet. But even though he is the subject in the grammatical sense, he is not the subject in the real personal sense. Every effort is made to depersonalize him and to eliminate every subjective factor. Invoked by the drive for generalization and specialization, objectivity is the password throughout." (Dr.Guttentag) (p.24)

RISK TO THE PATIENT:With but few exceptions, all experiments are a voyage into the unknown, and thus they must carry some risk of the untoward happening. The informed patient who accepts that risk is gambling, but an important feature of that gamble is that the patient has personally something to gain if the experiment is directly concerned with the relief of his symptoms. But the position is entirely different if there is no likelihood of the patient himself benefitting.

Notice that what may appear relatively innocous to the hardened experimentor can produce extreme distress, including a good deal of fear, in a patient who is being subjected to something he does not understand properly. Such distress, endured by the subjects of experiments, is rarely recorded in medical publications and often appears to be of small concern to the experimentors who have caused it. (E.g.Massive haemorraging caused by the accidental piercing of the spleen, kidney or liver, causing severe physical and mental distress to the patient, may be recorded as a trivial accident immediately corrected by blood transfusion.) (p.25-26)

Even a technique which can be employed safely in the hands of a skilled expert should not be used for experimental purposes. E.g."Needle biopsy of the liver should be regarded as potentially fatal. Five hundred biopsies may be performed without incident, only the five hundred and first to be complicated by massive intraperitoneal haemorrage demanding immediate treatment. The patients must therefore be carefully selected and a real indication for it must be present before a biopsy is performed." (Dr.Sherlock, a noted medical researcher) But what is a 'real indication'? Can an experiment the possible findings of which can be of no possible use in the treatment of the patient be said to be based on a 'real indication'? This is the core of the matter.

There is one further point regarding risks and rights of the patient and those of the doctor. Though not everyone will agree, the view should be heard that even a willing and informed patient may not be morally justified in accepting certain risks. It can be maintained that everyone has a certain moral obligation not to run undue risks with his own health or life. "The patient, then, has no right to involve his physical or psychic integrity in medical experiment or research when they entail serious destruction, mutilation, wounds or perils."(Pope Pius XII, Sept.1952, to International Medical Congress) (p.41)

THE PRINCIPLE OF MEDICAL MORALITY:Many experiments are defended by those carrying them out on grounds that while admittedly of no help to the patient or other person who is the subject, the aim of such experiments, is ultimately to help mankind. My contention is that it is immoral to perform experiments, especially dangerous ones, on unsuspecting patients not suffering from the disease being investigated, solely in the hope of making scientific discoveries. Science is not the ultimate good, and the pursuit of new scientific knowledge should not be allowed to take precedence over moral values where the two are in conflict. The statement which is not uncommonly heard among research workers, 'It would be interesting to know', though natural and, doubtless, frequently true, is

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IN SEARCH OF A CHRISTIAN MEDICAL ETHOS

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AT a time when codes seem outmoded and almost inoperable, and ethics seems to be little more than a convenient way of doing business, when secularism is making inroads into faith, and religious indifferentism is gnawing away at the entrails of religious fervour and practice, it is an awkward question to ask: "Is there a Christian Medical Ethos?" But, in an age of searching — inexorable, rigorous, incisive and honest — this question must be asked by every sincere Christian doctor, if he is to find meaning in his being both a doctor who is a Christian and a Christian who is a doctor.

About 20 years ago, at an international meeting of Christian doctors at Tubingen, Germany, the question was posed: "Is there a place for continuing to run Christian hospitals?" Whereas some, among them clergymen, challenged the propriety of having 'Christian' hospitals, the assembly came to quite the opposite conclusion at the end of the meeting. The assembly of Christian doctors felt that there are problems, mysteries, perplexities connected with healing, living and dying, to which secular medicine has no answers, and upon which the Christian Gospel of the death and resurrection of Christ does throw light.

Is not this the perennial question we keep posing to ourselves: What difference does it make that one is a Christian? Does his Christian faith make him a better, or different sort of, doctor than his non-Christian colleagues, leaving aside their respective technical competency or diagnostic skills? A christian doctor must answer this question if he is to find the meaning and relevance of his faith in his professional life, and accept courageously and cheerfully the challenges that an increasingly secular climate of opinion and attitude will inevitably pose to his Christian conscience.

When speaking of 'difference,' we must beware not to think in terms of 'better' or 'worse'. The question, as C. S. Lewis rightly suggests in his book MERE CHRISTIANITY, is not whether being a Christian makes you a better man than someone else who is not, but, rather, whether being a Christian has made *you* a better person than if *you* were not a Christian. To use a commonplace medical analogy: to ask whether Miss Buxom is healthier or not than Mr. Pehlvan because she takes Multivits and he does not, is a meaningless question. The real question is whether Miss Buxom is healthier because of the Multivits than *she* would be without them. Hence, we should be asking ourselves whether the right understanding and living of Christianity makes better persons of us or not. In the same way, would it make a difference to the doctor's understanding of his role and mission in life that he has accepted the challenge of the Gospel, through a personal commitment to serve his ailing neighbour after the example of Jesus Christ? Obviously, we are speaking not of the nominally Christian doctor but of one whose vision of Jesus, the Great Physician, brings him to see his calling to be a doctor as a *mission;* of one who takes seriously suchlike sayings of Jesus to his disciples (among whom he counts himself): "You are the salt of the earth. . . you are the light of the world." Such a doctor would legitimately be expected to ask: 'Is there a Christian medical ethos?'

We must now explain the word *ethos.* An ethos is different from a *medical code,* or from *medical ethics.* Whereas a medical code provides the framework for the acceptable form of behaviour that would safeguard the doctor, the profession and the rights of the patient; and medical ethics would represent the systematisation of moral judgements involved in making medical decisions; an ethos is the value-system that influences the formulation of both code and ethics. The ethos is the way a man experiences, sees, and relates himself to, the world and to his fellowmen—is his fellow-man a thing, an object, to be manipulated and used for self-aggrandisement; or, a rival over whom he must gain ascendancy, exercise control or wield power; or, a neighbour, *his* neighbour, one who makes an imperious demand on his love and respect, one for whom he must care in his need, and for whose benefit he must strive to ameliorate the social and ecological conditions of living?

It seems obvious that in arriving at an ethos particular to his profession, the doctor should consider not only the existing code, but also the convictions and ethical behaviour of conscientious colleagues. But, we may well ask, is this 'medical ethos' to be restricted to a lowest common denominator of accepted values? Can a doctor be satisfied with an ethos based on a moral values (if one could truly speak of such), on values determined by the *utility-*, or, *efficiency-*, or, *profit-*, principles that so regulate a materialistic society? Can an "everybody-does-it" principle form the basis of a justifiable medical ethos? Is there not room for a Christian medical ethos?

DIMENSIONS OF A CHRISTIAN MEDICAL ETHOS

A Christian medical ethos must spring from the Christian faith. It must spring from the understanding the Christian doctor has of his vocation in the light of his faith. A Christian physician who models himself on Christ—whom Christian tradition has given the singular title: The Great Physician — would obviously have a set of values which he would not have, were he bereft of this faith.

1. *The Concept of healing:* To a great degree, the formation of a Christian ethos would depend on whether there is a Christian concept of healing. It is to be noted that a very specific sign of the Kingdom of God, mentioned in the Gospels, is the healing of the sick. Even the forgiveness of sins is linked with the healing process. "Go, sin no more. Your faith has made you whole" (where 'wholeness' refers to total well-being, which is an adequate definition of health). Is it too much of a surprise, then, to note that the ultimate injustice is described, among others, in terms of refusal of health-care: "I was ill and you did not come to my help" (Mt. 25, 43)? A Christian doctor through his work of healing shares in the mission of Christ; he proclaims the Good News through his ministry of healing, thus extending the frontiers of the Kingdom of God, or, if one dislikes the triumphalistic overtones, makes the kingdom more present among men. In this ministry, he is God's instrument, doing God's work of redemption. Both his personal life, then, and his dedication to his healing function, must proclaim

the presence of God. Besides, he will accept the obligation, before God, for the health of the individual for his *total* health as a *person,* and, through him, for all those who need his care. He is, in a word responsible *to* God, and responsible *for* his fellow-man's health, and is bound to provide the *best* ministration he can in the situation.

This last phrase may sound like a pious cliché, but, as a Christian, a physician must ask : "Before God, what is the best ministration in *this* situation ?" In other words, can one rest content with the *status quo* of current medical practice and accept the 'non-choice' approach that characterizes so much of today's medical services? Is the Christian doctor — and, by extension, the Christian medical institution and the Church(es)— to view his medical mission as meaning 'to provide the best care to those who *come* to him,' or, must he go further and assume responsibility for those, too, who do not come because they are either ignorant, or can't afford the fees, but are in fact most in need of his care ?

Our Christian concern must determine the way we fix our priorities. A pediatric Mission-hospital in Africa had an excellent record of service and of care provided to every child that was brought to it. At the same time, during the 50 years of its existence, the infant mortality rate in the area served by the hospital remained at around 282 per thousand births. While providing excellent care to the children, *brought* to the hospital, its authorities had failed to provide basic, life-saving care to the numerous children that were dying of 'neglect' in the surrounding area. It's excellent doctors were too busy saving a few at the expense of the many. In terms of costs, one could say that the cost of saving one child on whom, say, the equivalent of Rs. 500 was spent, whereas, if the same amount was diverted towards providing even basic medical care, ten children instead of one could have been saved, was, *in fact,* Rs. 500 *plus* 9 deaths. We need specialised hospitals and specialist doctors and excellent care ; but we also need to think in terms of the greatest good for the greatest number. It is a case, therefore, not of "either-or" but of "both-and." Incidentally, in the above mentioned case, the infant mortality rate was brought down to 78 per 1,000, within five years, through the action of a concerned pediatrician, newly arrived, who requisitioned the services of 15-year old girls, from the local mission school, to provide the basis of health education and health care. (This is a line of thought and action that GPs., with a large and comfortable practice, could fruitfully consider). We need constantly to re-evaluate our concept of "service" in the light of the Christian imperative of "caring." Perhaps we would find plenty of which to be ashamed in our "service."

The Christian's one guiding law is that of love, which someone has paraphrased as meaning : "to care enough about others as to want to do something about it." How does one "care enough" in a Christian way especially when we know that needs will always exceed resources ? There are no ready answers, but we must keep asking ourselves the question, often an agonising one. One suggested criterion for helping us fix our priorities is that of the "Poor." The "poor" are not necessarily the poor in any simple economic sense, but rather the neglected, the ignored, the rejected, the drop-outs of society, those who are not cared for and to whose care no prestige is attached. Where there is a pioneering need to do this, because nobody else will give attention to it, then it is a Christian calling. As Christians our particular, though not exclusive, concern is to care for those who are not cared for ! Each Christian doctor must listen for this specific call of God, in the secrecy of his heart, to such service within the framework of existing situations.

Another aspect to this 'service' must be considered. It is not always, nor only, a question of what a Christian doctor should do in terms of individual service. Practically speaking, much, in a developing country, has to be undertaken by Governmental agencies. The Christian responsibility of the doctor, then, would *also* consist in exerting himself to bring pressure to bear on the right spots, and on responsible persons in public office, to ensure that health-justice is provided for those who, in his Christian conscience he feels, must be cared for, and when such care can only be provided by public agencies. To give an example : concern for the rights of the unborn, in the face of liberal abortion legislation, must make Christian doctors want to do something about getting a different sort of social legislation (that would, for instance remove social stigmas like illegitimacy) passed, and about working for the setting up of counselling services for distraught women seeking abortion and Homes where, they may be helped to have their babies with dignity and without "fears."

The Christian vision of man, as it is worked out in the community of believers, must further influence the development of a Christian doctor's ethos. This understanding of man will bring special light to bear on some problem-situations, such as those which come up in genetics and human reproduction, medical experimentation and the dying-event. Further, it will affect one's dealings with one's patient, and the respect due to him coupled with the obligation of not taking advantage of his helplessness to feed one's greed. It will determine the nature of the medical secret, the obligation to respect the conscience of the patient, and his right to know the truth about his illness.

2. *Other dimensions :* One could bring within the scope of his Christian ethos the doctor's obligation to, and relationships with, his colleagues, especially the junior doctors who have to set themselves up. Too many doctors enter into a rat-race for patients, and bigger practice, at all costs! Not merely professional decency, but effective charity — really caring enough for one's colleagues, and their welfare, as to want to do something about it — should determine right relationships. Is "group practice" a Christian answer ? Or, entrusting part of one's burgeoning practice to a junior colleague ? Each Christian doctor must find his Christian answer to the demands of love in his own life situation.

Still another dimension is the Christian doctor's relationship with his own family. His absorption in his work, whatever the motive he professes, may make him not care enough for those for whom he is obliged to care. Further, living as he does in an under-developed country, the Indian Christian doctor cannot absolve himself of the obligation of thinking in terms of the needs of the country and the community, in fixing whether he is going to specialise or be a G.P., whether he will practise in the town or in the mofussil, whether he will serve in the country or go abroad (to get job satisfaction, or to ensure the security of himself and his family). This is an *ethical* decision from which the doctor cannot escape, for, in fixing his "priority," he is determining the measure and quality of his service and charity. To be, in India, an U.S.-qualified neurosurgeon, *may* mean that one restricts one's service to a microscopic minority, composed in the main part of those who live in the larger metropolitan centres, and who can afford the fees. Of course, the country needs specialists — but the decision to be a specialist, or not, must be taken in accordance with his Christian vision of the demands of love in his life-situation.

Finally, his *Christian ethos* must make him care enough for himself, giving himself the time to relax and to pray, to build up the resources of his faith, so that the frustrations of growing in age may not make him a cause of *ennui* to others.

Conclusion : The Christian doctor, indeed, must keep searching for a "specifically *Christian medical ethos.* His, faith, which he must ever strive to keep alive, must make him view his task not merely as a profession but as a calling, a mission, *i.e.*, a 'being sent forth' to carry out, in its total sense, the healing work of Jesus. While loyally giving ear to the teachings of the Church's Magisterium, he must remember that he too is a partner in listening, and active sharing, in the process involved in making *moral decisions* relative to complex *medico-ethical problems.* He must be prepared to, and, in fact, conscientiously ask, the daring, if upsetting, question : "What more does God expect from me?" "Am I *really* caring enough so as to fix the right priorities according to the mind of Christ whose minister of healing I am, and to the promotion of whose kingdom I must dedicate myself?" Many questions are unanswerable, or are not immediately answerable. That is the risk involved in the search ! But the search, in Christian tension, must go on and the Christian doctor must be prepared to act according to his Christian insights. A medical ethos based on such Christian Searching will certainly make a *difference*—hopefully, for the better !

THE FAMILY DOCTOR

(An Eulogy)

By Dr. Fred Noronha

IT is perhaps no exaggeration to say that no greater honour, responsibility or obligation can fall to the lot of a medical practitioner than to become a Family Doctor. For such an assignment, he needs not only the scientific skills of his profession, but also human understanding, courage, wisdom born of experience and emotional maturity if he is to provide this unique service to his fellow-men. The Family Doctor is not a mere healer of disease, he is also a friend, confidante and counsellor to the family he treats. He is, in fact, a privileged person. In his traditional role, he not only endeavours to prevent and cure disease, whether of body or of mind, but also enters into a more personal relationship with every member of the family. To him, each of them is a person and, he attempts not only to consider the physical and psychological problems of his patients, but also to view each of them in his correct perspective in relation to his environment, occupation, social milieu and genetic constitution, all of which may have a bearing on the health of his patient and, through him, on the health of his family. He gives them intelligent and humane care with tact, sympathy and understanding. For him, the patient is not a mere collection of interesting signs and symptoms arising from disordered function, diseased organs or distorted emotions, but a complete person, made up of body, mind and soul. He really cares for his patients ; a misanthrope could never be a good Family Doctor even though he might be a brilliant diagnostician.

A dedicated Family Doctor brings to the ailing patient and his anxious family a feeling of confidence and security. Illness often creates problems for the patient and members of his family such as, interruption of daily domestic or occupational activities, financial embarrassment, fear, anxiety or depression. Moreover, illness sometimes profoundly alters personality or constitutes a threat not only to the patient's bodily integrity, but also to his status in society. A person in such situations often seeks the help of another on whom he can rely as a trustworthy friend. The Family Doctor fulfils the need admirably.

The Family Doctor's grasp of the patient's personality, background, hereditary traits, environment etc.,, places him in the unique position of being able to know his patient in his totality, a fact which enables him to evaluate symptoms more accurately and intelligently, and often to diagnose an illness early. An early diagnosis generally implies less suffering, speedier cure and less expense to the patient.

Strange are the psychological attitudes which some patients adopt when ill. Some appear to take a secret delight in illness and resent anything that threatens their invalidism ; others refuse to face facts or bellittle their symptoms ; others again, try to adjust their distorted personalities to the environment by one or other of those devices known to psychologists as "mental mechanisms," and so on. These phenomena are not susceptible of solution by the use of precise scientific methods, but require profound experience of human nature, and some degree of maturity to probe beyond surface motivation and behaviour, see accurately and deeply the problems of another human being and tackle them satisfactorily.

One often hears of tragedy stalking unnoticed, in certain families, merely because its roots were not detected early enough or not at all. The Family Doctor has a grave responsibility in such situations. Fitted for the task by training and practical experience as well as his intimate association with the members of the family he treats, he often can and does detect the presence of an unwholesome environment or unhealthy trait or attitude on the part of one or other member of the family. It is not uncommon for an alert Family Doctor to avert or nip in the bud, by his timely intervention, an abnormal situation. Many a conscientious Family Doctor has saved an emotionally insecure child from future tragedy, effectively diverted a floundering adolescent from the path of delinquency, successfully advised against a hazardous marriage, averted suicide in a depressive, restored an alcoholic to sobriety, helped an elderly patient to lead a happier life despite his disabilities and performed a hundred and one intangible services which his unique relationship with the family made possible.

The Family Doctor is often faced with the sadder aspects of medical practice. Few problems are more distressing than those presented by the patient with an incurable or fatal disease. With tact, and deep understanding of human nature, the Family Doctor knows when, what and how much to say about the illness, to his doomed patient. The dedicated Doctor has often succeeded in bringing warmth and cheer to the patient and his family in such situations. He has to draw heavily on his humanity, mature judgment and intuitive talent on such occasions and be careful to avoid unnecessary psychic trauma both in the patient as well as in his relations by avoiding words and actions which are potentially introgenic. An indiscreet remark, a solemn bedside conference or an ominous frown For Examples could each of them cause untold harm to his anxious patient of his relatives. Yet he, owes a duty to his patient to encourage him to prepare himself for death both in the material as well as in the spiritual plane. When death occurs, there are the survivors stricken with grief who also need his attention. Often, he need not do or say much in such a situation, His mere presence and a few consoling words may help lighten their sorrow and feelings of helplessness.

The essential difference between the family Doctor and his other colleagues lies in the former's professional attachment to the family he treats . He is above all, a personal physician to the members of the house-holds, and his service is personalized. From this relationship there flows a two-way traffic between the Family, and the doctor. Genuine affection, mutual respect, loyalty, confidence and trust in the doctor on the one hand, and concern, sympathy, professional integrity on the other. Such is the foundation on which a most fruitful doctor-patient relationship thrives.

Some people, unaccustomed to the ministrations of a Family Doctor, might conclude that such an entity does not exist save as a figment of one's imagination. The fact is that changing patterns of society and a variety of other circumstances are creating an atmosphere in which the Family Doctor can no longer function qua Family Doctor and may soon face extinction. On the other hand, since no other system of medical care can fully and satisfactorily replace this unique institution it seems reasonable to expect a resurgence of the Family Doctor in future albeit in a new garb. The family Doctor of the future will, like his predecessor be a non-specialist and very human General Practitioner who will care for his patients and not merely treat them. He will of necessity, be equipped with superior training and knowledge, and adapt himself to an entirely new pattern of society. He will steer clear of all those influences which tend to turn him into a superb technician fit only for the practice of a soulless medicine and preserve the truly humane character of his noble profession.

GUILD NEWS

Our column 'Guild News' was held over for want of space in the past three issues. A brief account of some of our activities during the last quarter is given here:—

Annual Mass

The annual Thanksgiving Mass to celebrate the feast of St. Luke was held at the St. Xavier's College Chapel on Sunday, 17th, October. The Rt. Rev. Dr. Simon Pimenta, Auxiliary Bishop of Bombay was the celebrant and preached a very impressive homily. The fraternal repast followed at the college cafeteria. Welcoming Bishop Pimenta, Dr. A. C. Duarte-Monteiro, our President said that in keeping with the past tradition the Guild took the first opportunity to invite every new Auxiliary—representative of our Patron—as Chief Guest. His Lordship then spoke in glowing terms of the good work Bombay Catholic doctors were doing; he said he was happy to be admidst them and offer prayers for the living and the deceased members at the Thanksgiving Mass. Dr. C. J. Vas, Hon. Secretary proposed the vote of thanks.

Biennial Meeting

After breakfast, Members assembled at the College Council room. The retiring President was in the Chair. The Biennial report printed for the occasion reviewed the activities of the Guild for the two years April 1969 to March 1971. The audited Statement of Accounts, as well as the Report were duly approved and adopted. At the elections that followed, following Members constituted the new Executive Committee :—

Dr. Juliet De Sa Souza, and Dr. Eustace J. De Souza were elected President and Vice-President respectively; Drs. C. J. Vas, (Mrs.) F. de Gouvea Pinto, (Mrs.) J. N. F. Mathias and Terence Fonseca, were re-elected while Drs. Olaf Dias, Miss Charlotte de Quadros, Miss A.C. Duarte-Monteiro, and F. Pinto de Menezes were elected as new Members. Messrs. C. N. de Sa & Co. were re-appointed auditors, Dr. A. C. Duarte-Monteiro thereafter thanked the retiring committee for their assistance, and dedicated service rendered during the two years that elapsed. He recalled that he was President for four years, and he felt happy to hand over the Guild to his successor in a very good shape, judging from the activities undertaken, financial stability, solidarity as also relationship with the Junior Guild. He then vacated the Chair in favour of the new President Dr. Juliet De Sa Souza, who thanked all members for electing her unanimously, and assured them that she would maintain the high tradtions established by her predecessors. She referred to the dedicated service rendered by Dr. Duarte-Monteiro who gave a fresh life, full of vigour and colour to St. Luke's Guild. The meeting terminated with a prayer and vote of thanks to the Chairs.

Cardinal Gracias and Dr. Menino de Souza Felicitated

A special function—Tea-party—was held in the Junior Gymnasium Hall, St. Mary's High School Mazagon to felicitate our Patron, His Eminence, Valerian Cardinal Gracias, on his Episcopal Silver Jubilee, an also Dr. Menino De Souza on his being the recipient of Papal Knighthood. This function was fixed for the 23rd October last, the 71st birthday of His Eminence. Unfortunately he was not in town, as he had to attend all Sessions at the Synod of Bishops from 30th September to 6th November. On his return after five weeks he was caught—to put it in his words—"in the stream of deep anxiety for the future," The Indo-Pak conflict and circumstances that followed. Despite the fact that, 2nd of January happaned to be a day when there were several other functions in the city, St. Luke's Medical fraternity mustered quite a good strength with their families and children, in the nature of a large Family Gathering. The President Dr. Juliet De Sa Souza, gave expression of the feelings of joy of Members, and offered felicitations on behalf of the Guild to the Cardinal and chevalier De Souza. She referred to our Patron's keen interest and association with the activities of the Guild. She also referred to dedicated work of Dr. Menino De Souza in several spheres, civic, academic socio-cultural, and political, particularly in "fund-raising" for several charitable and educational causes. His Eminence, in a very eloquent reply, thanked the Guild for their greetings, and good wishes. Tracing his associations with the Guild from 1938, he congratulated the Members for maintaining a high standard which was due in large measure to the Presidents and the Committees. He said he was particularly happy to read the Guild Bulletin regularly since 1949 ; Stressing that the bulletin was indeed 'an accomplishment,' he exhorted members to see that it *appeared uninterruptedly*. Dr. Menino thanked the President and Members of the Guild for their felicitations and good wishes. He said he followed very keenly the activities of the Guild and congratulated the Committee for the progress they had made in recent years. He said Dr. Duarte-Monteiro, who was Guild President for four long years was greatly responsible to give it a 'new look' and a "good shape." Dr. C. J. Vas, the Secretary then proposed a vote of thanks.

The function—punctuated by recorded music refreshments, and variety of games for young and old—proved to be quite an enjoyable one due primarily to the efforts of the office-bearers, and assistance, of Drs. Terence Fonseca, Miss Carole Duarte-Monteiro, Denzyl Duarte-Monteiro, and young Fonseca This may henceforth turn out to be a regular featur of the Guild, to enable members with their families meet at a *get-to-gether* during X'mas Season, and organise sports, games, or X'mas-tree for children.

FIFTH ASIAN CONGRESS FOR CATHOLIC DOCTORS

(Bangkok—1972)

The Fifth Asian Congress of Catholic Doctors will take place in Bangkok, early in December this year. It will be recalled that on the occasion of the IV Asian Congress held in October 1968, the assembly had unanimously authorised the Catholic Physicians Guild of Thailand to organise and play host for the V Asian Congress.

An unique feature of the Fifth Congress is that plans are formulated to include it in the First Ecumenical Conference of the Catholic Organization and the Christian Medical Associations in Asia, jointly sponsored by the Asian Regional Executive Committee of the FIAMC (International Federation of Catholic Medical Organisations) and the EACC (East Asian Christian Conference), although with a separate prc gramme.

A Tentative Agenda of the Fifth Asian Congress is outlined here. Further particulars of the First Ecumenical Conference, as well as of the *Asian Congress of Catholic Doctors* will be given in our subsequent issues.

Tentative Agenda.

Subjects for discussion

1. F.I.A.M.C. Status and Bylaws (as amended and approved by the Convention 1970).

(*a*) Membership problems (National Organization and Fees).

(*b*) Regional Executive Committee problems (Meetings, cost for travelling, duties and obligations).

2. (*a*) How does the work of your organisation benefit from F.I.A.M.C.

(*b*) How can Catholic Medical Organisations in Asia benefit from one another.

(*c*) Closer relationship between Doctors, Nurses, and Para-medical workers.

3. Closer relationship among Chirstian Medical Organisations in Asia.

(*a*) Joint Regional Conference ?
(*b*) Joint National Conference ?
(*c*) Joint National Committee ?
(*d*) Joint Activities of National Level ?

4. (*a*) Election of Regional Executive Committee for Asia.

(*b*) VI Asian Congress—Where ? When ?

TRANSPLANTATION - THE MORAL ISSUE

INTRODUCTION: "As a result of medical progress, our technical decisions may become easier, but moral problems, on the contrary, will be increasingly significant." (Dr. J. Hamburger, ETHICS IN MEDICAL PROGRESS, Ciba Foundation Symposium, p. 136). Transplantation is one such field. Hundreds of people have been kept alive or helped to live because of transplantation of various sorts. Yet grave moral questions are being posed, and one reason for heart transplants going out of vogue, at least for the present, is precisely the ethical issue.

1. **MEDICAL APPLIANCES:** These are mainly of two kinds:

   a) **Prostheses:** i) Removeable e.g. dentures
   ii) Built-in e.g. orthopedic replacements, valves, etc.

   b) **Artificial organs:**
   i) Temporary e.g. heart-lung machine, artificial kidneys, etc.
   ii) Built-in: so far none are available for human beings, though an animal has been fitted with an artificial heart.

   There is no special moral problem connected with the use of these, though the decision to use any of them is a moral decision that must be guided by moral values which must be upheld in all medical practice.

2. **TRANSPLANTS:** These are of three sorts:

   a) **Auto-transplants:** ie. those that take place within the body of the person himself e.g. skin, cartilage, bone.

   b) **Homo-transplants:** i.e. those that take place from the body of one person to that of another. These include: blood transfusion, organ grafting e.g. of cornea, kidney, liver, heart, etc.

   c) **Hetero-transplants:** i.e. those that take place from the body of an animal to that of a human person e.g. sex-glands, organs (incidentally, the first heart transplant ever performed was that of a chimpanzee's heart to a 64-year old man, in 1964 in the U.S.A.)

   In the case of auto-transplants, we could follow the adage: "good medicine is good ethics". In the case of hetero-transplants, the grave question of possible "personality changes" must be considered e.g. Pope Pius XII stated that the transfer of an animal sex gland to a human being would have to be rejected as immoral because of the great disturbance to freedom which would likely follow. The integrity of personal life and personal identity prevail over prolonging life or any other possible advantage afforded by such a transplant. Finally, homo-transplants present more serious problems, and we must now consider these separately.

3. **HOMO-TRANSPLANTS:** The ethical situation changes with the source for obtaining the organ to be transplanted.

a) **Cadaveric transplants:** These involve tissues and organs removed from cadavers. It must be accepted that a person has the right to bequeath organs of his body for use after his death e.g. corneas. This would be an example of love

Duplicate

for one's neighbour. In the case of a person who has not so bequeathed his body, the doctor must obtain the consent of his relatives to the use of any part thereof. The practice of presuming such consent, or acting without it (e.g. as happens in some teaching hospitals and research centres), is a violation both of the law and of the rights of the relatives. Since cadaveric transplants present fewer ethical problems, doctors should work towards making their use increasingly feasible, medically. There are indications of better prospects in this respect, especially with regards to the use of cadaveric lungs and livers.

b) "Free transplants": This refers to tissues and organs removed in the course of ordinary surgical operations e.g. when kidneys are removed in the case of urethral cancer or the creation of a subarachnoid urethral shunt. With our present scientific know-how, these present an advantage over cadaveric transplants because of the contractile nature of the organ, while, at the same time, they do not involve the ethical complications which are present in "living donor transplants" (see below).

c) Living donor transplants: This refers to tissues and organs provided by living volunteer donors. Cardinal ethical issues are involved here since it touches upon two individuals, the donor and the recipient. One has to consider the risks both to the donor as well as to the recipient.

4. HOMO-TRANSPLANTS -- TWO SPECIFIC AREAS THAT AROUSE ETHICAL REFLECTION.

a) Blood transfusion: This procedure has literally saved thousands of lives, has prolonged others and made possible major surgical operations. It provides one of the best ways in which a man can be a good neighbour. Barring serious accidents of typing, sterilizing and labelling, reactions are rarely serious and they occur in not more than in about 5% of transfusions. The overall mortality rate is probably not higher than 3 in a 1000. However, it is hard to be sure of avoiding the transmission of hepatitis, syphilis and malaria (in some parts of the world). Moreover, as we learn more about individuality in blood groups, the development of a dangerous sensitization is a risk always to be kept in mind. Finally, there is the danger of taking the procedure far too lightly: "topping it off" or "giving a pint more just to be on the safe side" has sometimes, ironically, resulted in death.

How does one act when the patient refuses to accept transfusion for religious or rather reasons which are not medical (e.g. Jehovah's Witnesses, or racial bigots who refuse to have blood from "inferior " races or castes) ? Should the doctor resepct the prejudices of parents, when saving the life of the child is involved; or, of an adult who refuses to be transfused?

i) Many feel that the parents' or patient's wishes should be respected, because they are considering not merely their physical welfare but their spiritual welfare and future life - and, therefore, this takes one out of the realm of medicine. No doubt one regrets being thus constrained.

ii) Others feel that the refusal of the parents make it a police matter, just as a proposed human sacrifice would be, and they would consequently seek a court injunction to carry on a transfusion. Strangely, the Courts of Law do not speak with one voice on this matter. Among the various reasons for authorizing a transfusion of a child despite the objections of the parents, is that the child is not yet free enough to choose its religious convictions, and, therefore, must be given a chance to live in order to choose its convictions. In the case of a mother who needed a transfusion and refused it, the court ordered it to be done, because the mother had no right to sacrifice herself and leave her seven-month child without her services. In the case of adults, one reason for upholding transfusion is that since an adult has come for medical treatment, and insists on it, he must accept the treatment advised and recommended. In any event, in the case of anyone who refuses a blood transfusion, the doctor who feels that he should not respect the wish of his patient (or of the parent of his child -patient) should seek a court order to do so.

b) Organs from living donors: Two questions have to be posed and answered:

1. Is the procedure justifiable medically?
2. Has the donor the right to mutilate himself?

In reply to the first question, the major consideration revolves around the immunologic compatibility of the recipient with the available donor-organ. Odds are presently about 100 to 1 that a recipient will get a tissue type that exactly matches his own. Hence, the doctor, who would like to do all he can for his patient because he has a deep and irrepressible concern for his patient's needs, should be careful to also consider more the immunologic - compatibility of the available organ than the need of the patient in itself. This would sometimes mean that a surgeon would be constrained not to transplant, since the well-being of a person is to be understood to be more than a mere prolongation of life. It is interesting to note that for kidney transplants, except in the case of identical twins, probably no more than 15 patients in the world have survived more than 3 years. "The procedure is of unknown value in terms of the five-year or ten-year prognosis" (cfr. ETHICS IN MEDICAL PROGRESS, p. 67)

In reply to the second question, two points must be considered:

a) The risk to the patient. It has been calculated that the risk of nephrectomy to the donor is as follows: 0.05% as a post-operative accidental risk, and 0.07% as the risk of any kind occuring later to affect the remaining kidney. However, this statistic must not be lightly interpreted, and physicians must have a conscientious concern for the better procurement of organs which will obviate the necessity of risking a healthy donor.

b) The consent of the patient. Especially in this area when the donation by a close relative, or twin, affects the saving of a life, it is difficult to assess the genuineness of consent. The donor can be pressurised both by other members of his family, who might even consider him expendable(!) and by an inner pressure exerted by his own social and religious education concerning the value of self-sacrifice, etc. The doctor should be specially sensitive to freedom of consent. Sometimes the help of a psychiatrist is enlisted.

While it remains true that doctors should work towards procuring organs from cadavers, the question remains: within our present limited options, can a healthy person donate one of his healthy organs to save the life of another? The answer would seem to be in the affirmative. For, if we could accept that a man can, in self-sacrificing love, "lay down his life for his friend" when this is an act of service to the other, we could also accept that he bee premitted to give a healthy organ to save the life of his friend. However, in arriving at this decision the following must be considered:

i) Is there a proportionately good reason?
ii) Is there a reasonable hope of success?
iii) Will the 'damage' caused to the donor be such as to prevent him from leading a normal human existence?
iv) Has his consent been duly obtained?

5. TRANSPLANTS IN THE "TWILIGHT ZONE" - LIVING PERSONS OR DEAD BODIES?

We said, above, that the procurement of organs from cadavers would obviate many an ethical difficulty. The question about the moment of death has become a thorny one in view of new procedures that can keep up certain physiological functions (heart beat, respiration) even though irreversible brain damage has occured. Physicians, lawyers, philosophers and theologians must apply their minds to a re-defining of "the moment of death". (See notes on EUTHANASIA for details about the criteria for determining the moment of death). This will affect the determination of the condition of the donor - is he alive or dead? But the central problems of organ transplantation will remain, and will have to be settled by different and independent norms (see below).

6. FINAL CONCLUSION:

Once again in this question, as in so many others which we have considered in our course of Medical Ethics, we realize that there are disturbing cases in which the doctor cannot hope to find ready-made solutions by established standards. The dotor should guide himself by the basic principle of concern for the **person** of the other. On the one hand, then, he should beware lest " zeal for research is carried to the point which violates the basic rights and immunities of a human person"; on the other, he must work out together with experts from other specialities concerned with man (e.g. lawyers, philosophers, social scientists, theologians), some moral guidelines to assist him as he treads the paths of progress in medicine which he hopes will be to the benefit of man. Below is given, by way of example, a set of guidelines drawn up by two doctors with regard to transplantation of organs (cfr. Harmon L. Smith, ETHICS AND THE NEW MEDICINE, p 121)

1. Compassionate concern for the patient as a total person is the primary goal of the physician and the investigator.
2. Organ transplantation should have some reasonable possibility of clinical success.
3. The transplant must be undertaken only with an acceptable therapeutic goal as its purpose.
4. Risk to the healthy donor of an organ must be kept low, but such risk should not be a contra-indication to the voluntary offer of an organ by an informed donor.
5. There must be complete **honesty** with the patient and his family, including every benefit of available general medical knowledge and of specific information concerning transplantation.
6. Each transplantation should be conducted under a protocol which ensures the maximum possible addition to scientific knowledge.
7. Careful, intensive, and objective evaluation of results of independent observers is mandatory.
8. A careful, accurate, conservative approach to the dissemination of information to public news media is desirable.

(Drs. J.R. Elkinton and Eugene D.Robin)

Medical progress is going to throw up many questions to which no preliminary system of medical ethics can provide immediate and certain answers. The ethical training of a doctor, then, cannot be limited henceforth to the teaching of a few ready-made rules. To quote Dr. J. Hamburger once again:

> "To produce doctors who are strong men, who are not only honest and just in thought, but efficient in action; to develop in them an awareness of the value of human life; to convince them that their vocation is an extensive obligation to the individual and to the group: such, it would seem are the best means of facing the ever increasing difficulties of medical ethics"
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> (cfr. ETHICS IN MEDICAL PROGRESS, p.137)

The Catholic Medical Bulletin

ORGAN OF THE CATHOLIC MEDICAL GUILD OF ST. LUKE, BOMBAY

No. 83 SUPPLEMENT TO THE EXAMINER October 16, 1971

EDITORIAL

Our attention was drawn to the following comments in favour of 'mercy-killing' in 'The Times of India' under the heading "Human vegetables" (Current Topics, May 4th): "Thinking and talking about the unconventional may be distasteful to most people but this is an essential activity for man, the social and intellectual animal. Twenty years ago free and open discussions about sex or abortions were taboo, but thanks to the efforts of trend-setters such of the hypocrisy surrounding them has been stripped away. Euthanasia (or mercy-killing) is another subject which is still considered by confirmists to be unmentionable."

In support of his plea, the critic lays stress on the views of Lord Ritchie-Calder, the noted British science populariser and professor :—

"As a result of mental illness or degenerative diseases such as multiple sclerosis some unfortunate people turn into zombies; when advanced age compounds their disabilities, they become little better than human vegetables . . ."

The learned professor poses the following question :—

"How merciful is it to keep them alive with all the resources at the command of the modern medical practitioner ?"

Obviously the critic has considered man only from the socio-intellectual viewpoint, disregarding the ethico-moral, and even the rational one. The Catholic viewpoint considered from the latter angle, teaches us to respect human life, which is the basis for civilisation. Fortunately, in the same comments, while pointing out that "the Hippocratic oath prohibits euthanasia, the belief being that as long as there is a spark of life a man must be kept alive," he concludes that there is certainly another side to the problem, and that the issue needs to be openly debated in a calm manner. It will not be out of place to reproduce here what "The Himmat" writes in an editorial entitled "Of life and Death," wherein it compliments Pope Paul's firm stand on abortion and mercy killing :—

"The Vatican is to be complimented for its clear enunciation on abortion and euthanasia. In a letter to the International Federation of Catholic Medical Associations' meeting in Washington, the Pope said : 'Abortion has been considered homicide since the first centuries of the Church and nothing permits it to be considered otherwise to-day.'

As for putting those who suffer from incurable or painful diseases to death, His Holiness says :— 'Without the consent of the sick person, euthanasia is murder. His consent would make it suicide.'

Indeed a society where one satisfies one's desires without any responsibility for the consequences, and where the laws are created to encourage this irresponsibility, cannot be considered a mature and civilised society.

As an answer to the above question posed by the Professor, above referred to, we publish in this issue a talk given by the Chaplain of St. John's Medical College, Bangalore.

EUTHANASIA *

BY FR. DENIS PEREIRA, CHAPLAIN, ST. JOHN'S MEDICAL COLLEGE, BANGALORE

"DEATH in America," says a recent article in NEWSWEEK, April 6, "is no longer a metaphysical mystery or a summons from the divine. Rather it is an engineering problem of death's managers—the physicians, the morticians and statisticians in charge of supervising nature's planned obsolescence. To the nation that devised the disposable diaper, the dead are only a bit more troublesome than other forms of human waste." And a little later, quoting an American psychologist, the article goes on to say : "The dying no longer know what role to play. Most of them are already old and therefore worthless by our standards. There's simply no place for a human death when the dying person is regarded as a machine coming to a stop." (Kastenbaum)

It would seem clear from the above that any discussion of euthanasia must necessarily be preceded by agreement on a proper philosophy or theology of death. What does death mean to us ? Is it 'a machine coming to a stop?' Does it merely provide 'a bit more troublesome form of human waste?' or is it "in the eyes of us doctors, the great enemy against which we must fight with all our resources, backed by patiently acquired knowledge," and if so "is it reasonable that we should be indignant, that we should indulge in barren irritation, before this inescapable condition of human existence ?"

"Death" says Francois Mauriac, "is that terrible thing that happens to other people." In a world frenzied with the pursuit of pleasure and comfort, obsessed with its egotism, "death is an affront to every citizens' inalienable right to life, liberty and the pursuit of happiness." (A. Toynbee speaking of 'Death as being un-American'). But for the Christian, and the man of faith, death is not the end but a stage in living—the process of dying is in reality the art of living meaningfully in and through the process of dying. Death is the gateway of eternal life. It is the moment at which we ratify the fundamental options we make in life. If 'to live is to choose,' then to die—if that death is human and meaningful—is also an act of choice in simple words, a truly human death is one in which one ACCEPTS to die. This is what Dr. Elizabeth Kubler-Ross, in her book ON DEATH AND DYING hints at when she quotes one woman, who finally bowed to the sentence of death after steadfastly refusing to accept the fact of her impending death, as saying: "I think this is the miracle. I am ready now and not even afraid any more." She died the following day. It is to be noted, however, that the acceptance of death is not to be taken to mean that the person has the right to impose death on himself, to ask another to shorten his life, or to place in another the power to end it ! We have no right over life, even though we may have at times a right to die ! And this brings us to the question of euthanasia.

Etymologically, the word EU-THANASIA means

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* Talk to St. Luke's Medical Guild, Bangalore, on April 22, 1970.

Duplicate

“dying well” But that is not what it has come to mean in legal or medical parlance. From its original meaning of “dying well,” a perfectly innocuous and healthy philosophical value, it has come to mean “easy dying,” which is not the same thing, for this implies medical intervention to cut short the process of living in order to accelerate or rather induce death. Other words used to describe it are “mercy-killing,” “merciful release,” “voluntary euthanasia” or “easy death” (which, incidentally, is the name of a society started in England in 1935 to push euthanasia legislation through Parliament). and “the termination of life by painless means for the purpose of avoiding unnecessary suffering.” It is easy to see how ‘mercy killing’ can turn into ‘convenient killing’—but let me not anticipate.

A. EUTHANASIA in the strict sense means : “to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death.” Here we can distinguish between ‘direct euthanasia’, *i.e.* where the assistance is rendered intending death. This is murder, or cooperating assisting in suicide, or both, and is never allowed. And we can speak of ‘indirect euthanasia’ or the administration of treatment (*e.g.* to alleviating pain) with as a side effect, the acceleration of death. This last would better not be called ‘euthanasia’ at all. J. Fletcher calls this antidysthamasia’ (not prolonging the process of dying). “It is not euthanasia to give a dying person sedatives merely for the alleviation of pain even to the extent of depriving the patient of sense and reason, when this extreme measure is judged necessary. Such sedatives should not be given before the patient is properly prepared for death, nor should they be given to patients who are able and willing to endure suffering for spiritual motives.” (Directives Catholic Hospital Association, U.S. and Canada). It is obvious from this directive that the person must be helped to live meaningfully through the process of dying. The real problem is: to what extent must a doctor/patient prolong life? Always and at any cost ? We could perhaps be helped if we distinguish between ‘Prolonging life’ and ‘prolonging the biological process of dying’; or to put it in other words, we could visualise cases in which the prolongation of biological life may not really be ‘living meaningfully,’ whereas acceptance of death may be ‘living this moment as a human being’ even though biological life is shortened (of course without being directly terminated, which is plain murder even if done with the consent of the patient.)

Take the case of a dying person who is ready to die and wants to die. He is suffering. He is surrounded by medical apparatus. He has hardly any contact with his environment, his friends, his family. His children are kept away, and visitors not allowed. Would not a doctor be justified in instructing the nurse to take away the instruments and allow the children to be with the father even if this may well mean an earlier death? Indeed, this may well be the best way to help a person to live—through the process of dying meaningfully, even though the duration of the process is shorter. Keeping a person alive is not necessarily helping him to live, for living means more than biological survival. And in this case the duty of living becomes the duty of dying well. (The question as to whether a patient is bound to accept, and the doctor bound to prescribe, extraordinary means to prolong life could be discussed in this context—but this would take us far out of the scope of this talk.)

To summarise this part, I will now read out some norms with regard to “indirect euthanasia.”

1. “A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

2. Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community ; its members are not bound to prolong the agony for a human being.

3. There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available . In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances.” (L. Orsey, S.J.)

4. “I would urge that we promote the idea of *bene mori*, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. ‘Bene mori’ that is, allowing the patient to die peaceably and in dignity always justified.” (J. R. Cavanagh)

[*N.B.*—This conclusion presupposes (1). that all concerned act in accordance with the will of the patient; (2). that the patient is dying. The dying process is the time in the course of an irreversible illness when treatment will no longer influence it. Death is inevitable.]

B. EUTHANASIA IN A WIDER SENSE: Euthanasia in a wider sense is less complicated to deal with ethically. It includes:

(*a*) To cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.

(*b*) To cause death, for the sake of society, to a socially dangerous person, to persons, in general, who cannot live a moral life within society (the so-called ‘eugenic deaths’). This causing death for the sake of society may go to the extent of disposing of “useless” persons, the aged, etc.

One can easily see, especially in the light of the Nazi atrocities of World War II, how fraught with terrible consequences the admission of such a principle would be ! “From a purely medical point of view shortening or taking the life of a patient for the relief of pain is unnecessary. Moreover, it is a confession of professional failure or ignorance” (Dr. Graham). Further, “the practice of euthanasia would lessen the confidence of patients in their physicians, for the patient who was gravely ill might readily fear that his physician would judge his case incurable and so administer poison to end his life” (Healy). One could imagine the confidence one would have in confessional practice if the priests were sometimes justified in betraying the confessional secret. And lastly, as B. Bonhoeffer who was himself executed in a German prison camp, put it: “we cannot ignore the fact that precisely the supposedly worthless life of the incurable evokes from the healthy, from doctors, nurses and relatives, the very highest measure of social self-sacrifice and even genuine heroism,” and, we may add, has been the inspiration for much real research and advance in medical knowledge and practice (cfr. the heart transplant surgery by doctors who “would not give up”). Truly, euthanasia is bad medical practice.

Conclusion : In the course of the last few months, two of the Associate Professors of Medicine of our College, both excellent Hindu gentlemen, addressed our pre-professional class students. One of them, when asked about euthanasia said he would never practice it, because it was a doctor’s duty to protect life, and he would work to the end to prolong it ; the other, with touching candour, said : ‘There are times when I can’t help my patient to live longer. At those times I must know how to assist my patient to die well, saying the right word of encouragement and helping him to accept his sufferings.' In the face of death, this is exactly what a doctor should do. "We have helped our patient" writes a Catholic Doctor in an article in CAHIERS LAENNEC, December 1946, "in his suffering; we now help him to die, to die well, or more truly to be born again into eternal life." And he adds in the same article : "do not let us change by a merely spectacular attempt at medical intervention this last and precious contact between the living (*i.e.* the patient and his family), and this final possibility of colloquy with God on which eternity depends . . . . Shall we by a gesture aimed at the entourage, rather than the patient, and which does not even hide our human medical impotence, shall we run the risk of obstructing the light of this last vision of God, and thus prevent an adherence which often remains . . . the assurance of a happy eternity for the patient ?" Notice, the emphasis on the patient's right to die a human, meaningful death. And he concludes, and with this so do I, "in the apprehension of these serious realities, let us, on the contrary, pursue to the end our true role as doctors—our role of respect for life—towards all and inspite of all. . . The tranquil death which we desire for our patients, as for ourselves, is not necessarily the unconscious death which drugs, even prudently administered, can procure. We ask above all, a peaceful death with the soul t peace and abandoned to goodness and mercy which opens to it the gates of eternal life. The sweetness of death is in that vision of light and life."

AMONG THE REFUGEES

By. Dr. Henrietta Moraes

THE poor intern is considered neither a student nor a doctor. His budding potentialities are underestimated, and though he himself may overestimate them a wee bit, few realise the enthusiasm and dedication with which he could perform perhaps a few small wonders in any medical situation—if only he were given a chance.

When I heard of the urgent medical need of the Refugees, I was drawn by sympathy and also by the challenge it offered I was full of enthusiasm, prepared to fight against the diseases of the refugees and to make myself feel worthy of being a member of the medical profession.

The Bombay University was preparing to send a few male interns but with its usual fatherly and dogmatically conservative attitude, it refused to send interns of the weaker sex (though after a lot of consideration, it has just sent a few lady doctors too). Everyone at home, supported by a host of friends and relatives, decided that I would not return in one piece if I left. Finally after a lot of persuasion and many promises that literally bound me to spend more time safeguarding myself, I was allowed to go. I am very grateful to the Indian Catholic Charities—Caritas, for it was through them that I left.

I travelled to Calcutta with two compounders who had also volunteered. At Calcutta, where Caritas has its headquarters for its Refugee Relief Work, it was decided that we work at the Salt Lake Camp. There were many volunteers who had come through Caritas from all over India and abroad to help in the relief work. It was wonderful meeting these people who had come with an abundance of enthusiasm, cheerfulness and selflessness to volunteer in the service of the refugees. I would love to mention them here, but perhaps I dare not, for I could never forgive myself if in my thoughtlessness I mentioned some and forgot a few.

It was truly this spirit of dedication, co-operation and thoughtfulness on the part of the volunteers towards the refugees and to each other, that got us so involved in the relief work. One realised that however vast and urgent a situation, nothing could be achieved without some organisation and co-operation.

There were over 900 camps all along the eastern borders of West Bengal, Tripura, Assam, Meghalaya and Bihar. Most of the camps were organised by the government mostly through the individual State Governments. The government spent a great deal by way of shelter, food rations, immunisation and sanitation programmes in most of the camps. On an average the government spent Rs. 3 a day on each refugee and at present we have nine million ! The Indian Catholic Charities—Caritas was also doing a tremendous amount of work in looking after about 70 refugee camps. A number of other organisations such as CARE, CASA, OXFAM, Medico International, S.C.I., Red Cross, Hindustan Steel, Ramakrishna Mission were also very active. It provided, medical aid, shelter, clothes and food to the refugees. Salt Lake which was one of its biggest camps, was nearest to Calcutta and supplies were therefore brought in more easily and regularly. Transport to the camps further north was difficult and made worse by the floods. In addition, those camps also dealt with a continuous influx of fresh refugees under a persistent fear of military attack.

My first visit to the Camp created lasting impressions on me. I still remember walking through the sands of Salt Lake towards the camp. There stretched before us miles of endless barren sandy land with not a tree to be seen except for a few on the distant horizon. But this very land was teaming with two hundred thousand refugees trying pathetically to adapt themselves to hostile conditions. We could see hundreds of little tents huddled closely together and endless rows of barrack-like sheds built of bamboo-matting covering the shed completely except for the many little doors. Each door led into a dark damp area of about 20-30 sq. feet. One could see a few sad faces of the inmates peeping through and viewing us with an air of aloofness ; women garbed in tattered clothes and burdened with naked hungry-looking children, spiritlessly trying to light a fire with a few damp twigs or coaxing a listless child to eat what little food they had. Some of the children, with the starvation and hardship they had gone through, wore the brooding expression of the old on their sunken faces. One hardly saw little children playing together. There was no trace of curiosity or cheerfulness in their expressions.

Fresh arrival of refugees brought a wave of depression upon us. But it was something we were always to see. They had treked wearily with their bare feet blistered and swollen and with hardly any clothes. When it rained, their meagre flimsy clothes clung to their skins as they walked along at the same weary pace, in no hurry to seek shelter. There was hardly a day that a complete family arrived at the camp. We would often see a woman alone with her children and perhaps an old helpless relative. Many of the men folk had been killed, some had stayed behind to fight. Occasionally, a woman would tell us that her child or parent had died on the way, of exhaustion and starvation, or that she was not sure of the existence of her husband or older sons. And then some would beat their heads to the ground and cry helplessly. The refugees were so reconciled to their fate that it was really heartening when one saw a youngster helping an old disabled man to the dispensary, or a few little boys fighting to get into a puddle of water or a group of young girls peacefully singing a few songs.

The future held no promise and they were so bereft of emotion that one rarely saw one refugee voluntarily helping another.

Of the refugees, ninety per cent were helpless women and children and the same percentage of them were Hindus. Most of the refugees at our camp were illiterate. Most were landless farmers by occupation and very few had an occupation or trade.

Our greatest problems were nutrition, unemployment, sanitation and the continuous arrival of more refugees. Conditions were such that men worked for no payment. Every morning there were crowds of men waiting to be employed but so many had to be turned down. They were not permitted to go into the city to beg or work as there was so much unemployment among the local people themselves. To keep the refugees occupied arrangements were under-way to start schools for the children with the few educated refugees as teachers. Parts of the camp were cleared up for play fields for football, etc. There were sewing classes for the young girls and women. The men would soon be employed in bamboo matting.

Endless hours were spent by the refugees in patiently standing in unending queues, often in the scorching sun or heavy rains, for bread, rations, medicines or water. Caritas was supplying 20,000 loaves of nutrified bread daily. Even though one loaf was given to every four persons, there were many who went without bread and waited their turn the next day or the day after that. Each time they received the bread it was ticked off on their ration card.

We had a well supplied dispensary with a separate shed for minor surgery, bandages and injections. We examined about 600-700 patients a day.

We would go out every few hours among the queues and bring in the serious patients who often without murmur would patiently wait their turn. These patients would be admitted to our hospital. It gave us such joy when we were able to save many of them with the wonderful drugs and other medical aids that had been donated so generously by countries all over the world. We had a simple but fairly efficient numbered card system for the out-patients and we even kept an out-door and in-door patients register.

We realised how a few friendly words and a little attention could go a long way to make these lonely sick people feel better. This was brought home to us even more strikingly by a middle-aged man suffering from cirrhosis of the liver. It was a chronic illness and there was not much that we could do for him. As he had no one, to care for him, we let him remain in the hospital. When he made a nuisance of himself, we did not hesitate to shift him to a small empty tent. That night he hanged himself. This had such an impact on all of us that it made us feel guilty. Frustration may have driven him but if we had been a little more friendly and attentive we could have saved him. We immediately decided to reserve two big tents for those old and chronically ill patients who had no one to care for them.

Our hospital housed two hundred patients in a few sheds and tents. We had two tents for maternity cases ; two tents for the old refugees ; two sheds for children; one shed for adults and one for patients with diarrhoea. With the admission of many of the patients we had the rest of the family in the hospital too—living round the patient. If the mother accompanied the sick child there was often no one else to care for her other little children. Most of the patients were admitted for pneumonia, typhoid, cholera, dysentry, nutritional deficiencies, measles, chicken-pox and infective Hepatitis. Diarrhoea in children was quite the most persistent problem and would remain so with poor sanitation and nutrition. We had transport at our disposal throughout the day to transfer patients with acute surgical problems to the city hospital. If it was not for the dedicated work of the Sisters of Charity, the volunteer nurses and helpers (among them many were refugees) it would not have been possible to run the hospital.

The dead bodies from the hospital and camp were kept in a tent among sacks of sulfur and bleaching powder till they were disposed off. The refugees had been deprived of their Motherland and later their dear ones. It was only death that emotionally moved these people—but only into a deeper and unapproachable gloom.

One cannot say what the future holds out for the refugees—but with the blood, sweat and tears that these people have shed, we with them pray that Bangla Desh will be a reality.

I had spent one month with the refugees and though there was heaps of hard work we had our moments of happiness too. Caritas had provided all its volunteers with homely and comfortable quarters. Returning back after a heavy day's work or a strenuous night duty we were always sure to have waiting for us just the things we desired most. Our experiences at Salt Lake will remain as vivid memories never to be forgotten.

OUR FELICITATIONS

We offer our congratulations to the following students who have passed the University of Bombay Examinations held in April 1971 :—

Third M.B.,B.S.

Miss Premila Robert D'Silva
Miss Philomena Faustine Lewis
Mr. Eric Joseph Francis Pinto
Mr. Vernon Patrick De Sa
Mr. John Austin D'Souza

Second M.B.,B.S.

Miss Mary Margaret Carrasco
Miss Maria Prisca Colaco
Miss Sandra Frank De Souza
Mr. Chipriano Serafinho Fernandes
Mr. Gregory Michael Fernandes
Miss Aruna M. Fernandes
Mr. Christopher Joseph Lobo
Mr. Gilbert Dominic Lopes
Miss Alzira Francisca Mascarenhas
Miss Sarita Joan Noronha
Mr. Arun Charles Pinto
Miss Lorena Siqueira

No Candidates appeared for the First M.B.,B.S.

Our 20th Annual Social Gathering

Members of the Senior and the Junior Guilds, are hereby informed that the St. Luke's Annual Re-union will be held at the Bombay Presidency Radio Club, Colaba on the 4th December, with Nelly and her Orchestra in attendance. For further particulars kindly contact the Chairman of the Entertainment Committee, Dr. (Mrs.) Francisca de Gouvea Pinto (Phone No. 371630), or any of the following :—Dr. F. Pinto de Menezes, Colaba (No. 213010); Dr. Terence Fonseca, Byculla (No. 377264); Dr. (Mrs.) G. Silveira, Mazagon (No. 372958) ; Dr. John Fonseca, Mahim (No. 455623) ; Dr. (Miss) Charlotte De Quadros, Bandra (No. 533103) ; Dr. John V. Ribeiro, Santa-Cruz (No. 538877) and Dr. A. A. Soares, Chembur (No. 521352). Students may please contact representatives in the respective Medical Colleges.

AN APPEAL FOR HELP TO THE REFUGEES

It will be recalled that at a Meeting of various organizations of Bombay's Medical Practitioners held on the 9th April, 1971, a Committee known as the 'Bombay Medico Bangla Desh Aid Committee' was formed, and it was also decided that medicines and money be collected to help the refugees.

At another meeting of the representatives of St. Luke's Medical Guild, the Catholic Nurses Guild, the Catholic Relief Services and Caritas India, held at Archbishop's House on June 22, it was decided to appeal to Catholic Doctors including Interns, as also to the nurses and compounders to work as volunteers among these refugees in Bengal. It is heartening to note that a batch left Bombay on the 12th July, 1971 in response to this appeal. However, the need for volunteers continues more so because replacements will be required for those who are due to return on the completion of their period of service. While appreciating the generous efforts of our members and their families to alleviate the suffering of these refugees, we urge them to continue their activities in the collection of drugs, surgical dressings, clothing, coverings (particularly blankets), mats, sheets, sarees and the like, and deposit the collected articles at any one of the centres given below. For the convenience of members there are three different localities, North, South and Central :—

1. St. Peter's Parish (Bandra), for the suburban members.
2. Sodality House (Seva Niketan), central areas.
3. Nirmala Niketan (School of Social Work), 38, New Marine Lines.

A. C. DUARTE-MONTEIRO.

Topics dealt with in the present course of Medical Ethics

Sr Johns course in the early 1970s

I. INTRODUCTORY LECTURES:

1. What is Medical Ethics? (vs. medical etiquette) Basic principles of Medical Ethics.
2. The Concept of Health - a total perspective.
3. Health care priorities and social justice.
4. The Doctor -patient relationship
    - medical responsibility to the individual and community.
    - the doctor vis-a-vis social legislation
    - the medical secret.

II. PROBLEMS CONNECTED WITH THE BEGINNING OF LIFE

5. Artificial Insemination
6. Genetic engineering
7. Abortion

III. PROBLEMS CONNECTED WITH SEXUALITY AND MARRIAGE

8. Meaning of human sexuality
9. Contraception
    a) Motives and methods
    b) Morality
10. Abnormal~~ity~~ sexuality (e.g. homosexuality)
11. Masturbation
12. Marriage counselling (e.g. VD of patient and obligations to partner; sterility; impotence)

IV. PROBLEMS CONNECTED WITH THE INTEGRITY OF THE BODY AND OF THE PERSON.

13. Mutilitation, sterilisation
14. Psychosurgery, psychotherapy, narcoanalysis and hypnotism.
15. Experimentation on human beings

V. PROBLEMS CONNECTED WITH THE END OF LIFE.

16. The meaning of Death
17. Telling the truth to the patient
18. Prolongation of life and the problem of Euthanasia.

VI. SPECIAL SECTION.

19. Alcoholism and drug addiction
20. Transplantation (Blood transfusion & haemodialysis)

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Duplicate

2. <u>The principle of valid consent</u>: (see first five clauses of Nuremberg Code) To obtain the consent of the patient to a proposed investigation is not in itself enough. Owing to the special relationship of trust which exists between a p patient and his doctor, most patients will consent to any proposals that are made. Further the considerations .....(see text)

[illegible] individual, supersedes every consideration of what may benefit science or contribute to the public welfare. No physician is justified in placing science or public welfare first and his obligation to the individual, who is his patient or subject, second. No doctor, however great his capacity or original his ideas, has the right to choose martyrs for science or for the common good. As Claude Bernard the founder of modern experimental medicine put it: "The principle of medical morality consists then in never performing on man an experiment which could be harmful to him in any degree whatsoever though the result may be of great interest to science, that is, of benefit to save the health of others." The BRITISH MEDICAL JOURNAL (1962,2,1108) in an editorial wrote: 'Hundreds and hundreds of experiments have been conducted which conflict with the principles of medical morality or medical ethics, as enunciated by the founder of experimental medicine." (p.42-43)

"One cannot justify any and every act in the name of the common good and therefore not every use of human beings in research can be justified in the broad notion that in the end others will benefit from such experiments. We must approach the concept of the greater good with our other three affirmations always in mind: that we must protect life, that health is better than sickness, and that we treat individuals as persons and not simply as means." (S.E.Stumpf, Dept. of Philosophy, Vanderbilt Univ., Nashville) An American physician has stated the matter even more strongly: "Any classification of human experimentation as 'for the good of society' is to be viewed with distaste, even alarm. Undoubtedly, all sound work has this as its ultimate aim, but such high-flown expressions are not necessary, and have been used within living memory as cover for outrageous ends." (Dr.H.K.Beecher)

<u>ETHICAL PRINCIPLES</u>: Morality rests on what is right in itself towards the individual immediately involved, not on justification by result, even though that may possibly benefit a great many others. "An experiment is ethical or not, at its inception. It does not become ethical post hoc - ends do not justify means. There is no ethical distinction between ends and means. (Dr. H.K. Beecher) (p. 225)

A detailed account of most of the revolting experiments carried out by criminal doctors (convicted at the Nuremberg Trial) has been recorded by Mitscherlich and Mielke, and it is apparent that nothing of medical value was discovered. But I hope that all readers will agree that even if something of value had been achieved it would not even have begun to justify the vileness of what was done. <u>No</u> new scientific truth could have weighed in the balance against the suffering caused. Yet these professors claimed that they did not aim to cause suffering - that could be left to others - but that their aim was to serve medical science. Their guilt was that they ignored the suffering they caused in following this aim and that they persisted in practices which they knew were certain to cause suffering. And this ... is not <u>in principle</u> different from an experimenting doctor in a hospital in Britain or America, ignoring the suffering which he causes and persisting in experiments which he knows will cause suffering, especially when the sufferer has not volunteered for the procedure, but is subjected to it at the sole decision of the doctor. (p. 226)

<u>A CODE CONCERNING HUMAN EXPERIMENTATION</u> would be concerned with the following principles:

1. <u>The principle of equality</u>: No experiments should be contemplated, proposed or undertaken to which, if he were in circumstances identical to those of the intended subjects, the experimenter would even hesitate to submit himself or members of his own family, or anybody for whom he had any respect or affection. The idea that the experimenter is worth more than the subject is ruinous. (p. 230)

[illegible], most patients will consent to any proposals that are made. Further, the considerations involved are so technical as to prevent their being adequately understood by one who is not himself an expert. Two essential pieces of information are often deliberately withheld from the 'consenting volunteers', namely that the procedure is experimental and that its consequences are unpredictable. Moreover, in keeping a subject in the dark as to what is being done to him so as to avoid a refusal, the experimenter is, in fact, guilty of a fraud. (p. 232)

3. <u>The principle of prohibited subjects</u>: Experiments should under no circumstances be performed on mentally sick patients, whatever may be the technical designation of their particular illness. Nor should experiments ever be performed on the aged or the dying. This follows from taking the above two principles seriously. (Especially with regard to the dying and the testing out of new drugs, where the patient cannot be saved it is common humanity that he should be allowed to die in peace.) (p. 235)

4. <u>The principle of previous animal experimentation</u>: This is suggested by every code. (p. 238)

5. <u>The principle of the experimenter's competence</u>: The parts played by people who are actually unqualified medically should be limited.(p.240) **to** what they can do with complete safety. (p. 240)

6. <u>The principle of proper records</u>: If a patient consents to be subject of an experiment, what has been done to him is virtually part of his medical history. Neglect of proper records is thus against a patient's interests, against those of the doctors and against the interests of medicine.

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In all the above, I am opposed to inhuman clinical research and plead for its replacement by humane research. (Notice how, when speaking of 'mishaps', experimental physicians relate the mishaps to themselves and not the patients.) Every human being has the right to be treated with decency, and that right belongs to each and every individual and should supercede every consideration of what <u>may</u> benefit mankind, what may contribute to public welfare, what <u>may</u> advance medical science. No doctor is justified in placing science or the public welfare first and his obligation to his patient second. Any claim to act for the good of society should be regarded with extreme distaste and even alarm, as it may be a high-flown expression to cloak outrageous acts. A worthy end does not justify unworthy means.

(ibid, suppl.)

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not in itself a justification for making experiments of whatever kind. The welfare of the subject must also and always be taken into account.

Any human being has the right to be treated with a certain decency; this right, which is individual, supercedes every consideration of what may benefit science or contribute to the public welfare. No physician is justified in placing science or public welfare first and his obligation to the individual, who is his patient or subject, second.

Dr. Guttentag defined as 'experiments in medicine' "experiments on the sick which are of no immediate value to them, but which are made to confirm or dispute some doubtful or suggestive biological generalization. Recently this type of experiment has become more and more extensive." (p.22-23)

VERSUS

<u>PHYSICIAN-FRIEND</u>: "One human being is in distress, in need, crying for help; and another human being is concerned and wants to assist him. The cry for help and the desire to render it precipitate their relationship. Theirs is the relationship between two I's, like between two lovers, friends, pupil and teacher. I have called such a relationship 'the mutual obligation of two equals'.

[illegible] highlighted which have relevance to the whole field of medicine. Surely it will be very profitable to all doctors and students who read it.)

HUMAN GUINEA PIGS by Dr.M.H.Pappworth
(Penguin Books)

THE PROBLEM: For several years a few doctors in this country and in America have been trying to bring to the attention of their fellows a disturbing aspect of what have become commonc practices in medical research. These practices concern experiments made chiefly on hospital patients, and the aspect which is disturbing is the ethical one. In their zeal to extend the frontiers of medical knowledge, many clinicians appear temporarily to have lost sight of the fact that the subjects of their experiments are in all cases individuals with common rights, and in most cases sick people hoping to be cured. As a result it has become a common occurrence for the investigator to take risks with patients of which those patients are not fully aware, or not aware at all, and to which they would not consent if they were aware; to subject them to mental and physical distress which is in no way necessitated by,and has no connexion with, the treatment of the disease from which they are suffering;and in some cases deliberately to retard the recovery from that disease so that investigation of a particular condition can be extended. (p.15)

SUMMARY OF VIEWS ON MEDICAL EXPERIMENTATION: 1)Clinical research must go on,but there must be acknowledged and observed safeguards for the patients. At present such safeguards are virtually non-existent. 2) The majority of those engaged in clinical research act with the highest moral integrity,but an expanding minority resort to unethical and probably illegal practices. 3) Unless the medical profession itself stops the unethical practices of this minority,the public outcry will eventually be such as to cause opposition to all clinical research (p. 18)
"It behoves the medical profession to take the public into its confidence. The primary step is to recognise that difficult moral problems - indeed the moral dilemma - do exist for which help and guidance can be sought from many sources. In the end we have to accept the fact that some limits do exist to the search for knowledge."(Prof.P.A.Freund - Lawyer) (p.20)

WHAT CONSTITUTES A JUSTIFIABLE EXPERIMENT? "The science of experimental medicine is something new and sinister;for it is capable of destroying in our minds the old faith that we,the doctors,are the servants of the patients whom we have undertaken to care for,and in the minds of the patients,the complete trust that they can place their lives or the lives of their loved ones in our care."(Sir William H.Ogilvie,Surgeon)
"The moral obligation to perform all human experiments only after due regard to the sensibility,welfare and safety of the subject must never be violated."(Dr.S.S.Ketty) (p.21)

EXPERIMENTATION - in the loose and strict sense:"Every act of a doctor designed soundly to relieve or cure a given patient is experimentation of an easily justifiable kind. The patient's placement of himself in the doctor's hands is evidence of consent. The problem becomes a knotty one when the acts of the physician are directed not toward the benefit of the patient present but towards patients in general. Such action requires the explicit consent of the informed patient. It also requires more than this;it requires profound thought and consideration on the part of the physician,for the complexities of medicine are in some cases so great it is not reasonable to expect that the patient can be adequately informed as to the full implications of what his consent means. His trust in the physician may lead him too easily to say 'yes'."(Dr.Beecher)
"We should,I think,for present purposes,regard anything done to the patient which is not generally accepted as being for his direct therapeutic benefit or as contributing to the diagnosis of his disease, as constituting an experiment,and falling therefore within the scope of the term'experimental medicine'.((Prof.McCance-Prof.of Exptl.Med.)

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Duplicate

[illegible] in need, crying for [illegible] another human being is concerned and wants to assist him. The cry for help and the desire to render it precipitate their relationship. Theirs is the relationship between two I's, like between two lovers, friends, pupil and teacher. I have called such a relationship 'the mutual obligation of two equals.'

PHYSICIAN-INVESTIGATOR: "The physician-patient relationship of one who performs experiments of no immediate value to the person under observation is impersonal and objective because of the character of the research. Experimentation is the only basis on which they meet. But even though he is the subject in the grammatical sense, he is not the subject in the real personal sense. Every effort is made to depersonalize him and to eliminate every subjective factor. Invoked by the drive for generalization and specialization, objectivity is the password throughout." (Dr. Guttentag) (p.24)

RISK TO THE PATIENT: With but few exceptions, all experiments are a voyage into the unknown, and thus they must carry some risk of the untoward happening. The informed patient who accepts that risk is gambling, but an important feature of that gamble is that the patient has personally something to gain if the experiment is directly concerned with the relief of his symptoms. But the position is entirely different if there is no likelihood of the patient himself benefitting.

Notice that what may appear relatively innocous to the hardened experimentor can produce extreme distress, including a good deal of fear, in a patient who is being subjected to something he does not understand properly. Such distress, endured by the subjects of experiments, is rarely recorded in medical publications and often appears to be of small concern to the experimentors who have caused it. (E.g. Massive haemorraging caused by the accidental piercing of the spleen, kidney or liver, causing severe physical and mental distress to the patient, may be recorded as a trivial accident immediately corrected by blood transfusion.) (p.25-26)

Even a technique which can be employed safely in the hands of a skilled expert should not be used for experimental purposes. E.g. "Needle biopsy of the liver should be regarded as potentially fatal. Five hundred biopsies may be performed without incident, only the five hundred and first to be complicated by massive intraperitoneal haemorrage demanding immediate treatment. The patients must therefore be carefully selected and a real indication for it must be present before a biopsy is performed." (Dr. Sherlock, a noted medical researcher) But what is a 'real indication'? Can an experiment the possible findings of which can be of no possible use in the treatment of the patient be said to be based on a 'real indication'? This is the core of the matter.

There is one further point regarding risks and rights of the patient and those of the doctor. Though not everyone will agree, the view should be heard that even a willing and informed patient may not be morally justified in accepting certain risks. It can be maintained that everyone has a certain moral obligation not to run undue risks with his own health or life. "The patient, then, has no right to involve his physical or psychic integrity in medical experiment or research when they entail serious destruction, mutilation, wounds or perils." (Pope Pius XII, Sept. 1952, to International Medical Congress) (p.41)

THE PRINCIPLE OF MEDICAL MORALITY: Many experiments are defended by those carrying them out on grounds that while admittedly of no help to the patient or other person who is the subject, the aim of such experiments, is ultimately to help mankind. My contention is that it is immoral to perform experiments, especially dangerous ones, on unsuspecting patients not suffering from the disease being investigated, solely in the hope of making scientific discoveries. Science is not the ultimate good, and the pursuit of new scientific knowledge should not be allowed to take precedence over moral values where the two are in conflict. The statement which is not uncommonly heard among research workers, 'It would be interesting to know', though natural and, doubtless, frequently true, is

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MEDICAL EXPERIMENTATION

(Below are given excerpts from an excellent book by an English doctor who spent years studying this subject and kept a bulging dossier on the same. Many moral principles are highlighted which have relevance to the whole field of medicine. It is to be hoped that the reading of these notes will be profitable to all doctors and medical students.)

ON DEATH AND DYING

1. The Doctor face to face with death : Death is a frightful, fearful happening, which, we are convinced, "happens to other people", (Franceis Mauriac). Yet it is something the doctor has to face routinely in the course of his practice. He must face not only the dying patient but also his relatives to whom he has to break the news of the impending end. The patient expects his doctor to stand by him till the end, and in an existential way will ask the doctor about the odds for his life or demise. And, inescapably, the queries of the patient will become the question the doctor must ask himself: 'what is death'? If death is a big problem in the life of the doctor himself, if it is viewed as a frightening, horrible, taboo topic, he will never be able to face it helpfully with his patients. He might hope they will not bring it up, and would probably talk about other trivial things.

The Physician stands always on the side of life. He must wage the battle against death with all the strength of his competence and commitment. He must inspire in his patient the will to live and encourage the hope of recovering health. But if to live is to be free, then the highest point of personal freedom is the courage to face peacefully the prospect of imminent death. If the doctor considers the patient's death as the enemy to his profession, death as a professional battle lost, then in his desperate struggle against death he will not help the patient to serenity and balance, strength and effective personal freedom in the face of death. As a famous physician writes: "Not only for the dying patient but also for the doctor, does a strong faith generate an intensification of freedom. It allows the physician a full commitment to life without that obsession which considers death as the greatest of evils, since we consider death as belonging to the fulness of life. The free acceptance of death is the only real chance to get out of that death which seems to destroy all our strength, a last opportunity to assert our freedom." It should therefore be the doctor's endeavour to assist the patient in achieving a peaceful death. Pain should be relieved as much as possible, but with the main objective of ensuring freedom and peace. The fear of death, it's greatest terror, should be defeated. Only then can freedom mature.

2. The Meaning of Death : In acquiring correct attitudes, the doctor must ask himself, and answer satisfactorily, the question: "What is the meaning of death?" Below are given a few points as guidelines.

   (a) Death is something which happens to a person. Whereas death can be considered from different angles - cytological, physiological, philosophical, theological - each person apprehends his/her death as an uniquely expressive event. It is not 'a machine coming to a stop', nor 'a bit more troublesome form of human waste' nor 'an affront to our inalienable right to life, liberty and the pursuit of happiness' (Toynbee), but an intensely personal thing - a stage in living. The process of dying is in reality the art of living meaningfully in and through the process of dying. "Death belongs to life as birth does; the walk is in the raising of the foot as in the laying it down." (Tagore).

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(b) Death is a real factor in the meaningfulness of life. In the face of death, says Viktor Frankl, as absolute finis to our future and boundary to our possibilities, we are under the imperative of utilizing our lifetimes to the utmost, not letting the singular opportunities - whose 'finite' sum constitutes the whole of life - pass by unused.

(c) Death, for the believer, is also a significant religious event : It is, as it were, the occasion on which we ratify the fundamental options we make in life. Those who, for example, believe in Jesus Christ, and in his passion, death and resurrection, as a salvific event, gain a new vision of death. Christ transforms death into the greatest manifestation of trust in the Father and love for all mankind. For the Christian, death opens on to life eternal. Every doctor should try to be cognizant of the hope and faith of his believing patients, the better to help them to face the prospect of death with equanimity.

3. The Moment of Death : In view of organ transplantation, this question has acquired special significance. After all, a person dying is still a person living, and he keeps his elimentary human rights up to the moment when life becomes extinct.

In short, the principle that brain death is synonymous with the death of the patient (or death of the person) has found universal agreement. A Harvard University team that studied this question in depth gave the following criteria: "It stated that in order for brain death to be designated the subject should be in deep and irreversible coma; manifest a total un-awareness to external painful stimuli; have no spontaneous muscular movements or responses to external stimuli; have no respirations when not in resuscitator; have no elicitable reflexes; have pupils fixed, dilated, and unresponsive to light; and have an isollectric EEG (flat EEG), with the foregoing characteristics having been maintained over a period of 24 hours." (Archives of Internal Medicine, 124 - August 1969 - p. 226-227)

4. THE PROBLEM OF THE PROLONGATION OF LIFE AND EUTHANASIA.

The right to live humanly implies the right to die humanly , i.e. with dignity and in freedom. Does this mean that the patient has the right to end his life or the doctor to assist him in doing so? In a recent document, the American Hospital Association approved a 12-point Declaration of Rights of Hospital Patients, which grants to the patient the right, among others, "to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of his action". This implies that an adult patient with no prognosis for recovery has a right to die without medical therapy. The point is: would this "right to die" justify the patient in asking the doctor to end his life, or justify the doctor in presuming this consent and acting in such a way as to cause death ?

THREE POSSIBILITIES : In the management of terminally ill patients, or patients whose brain has suffered massive destruction to the extent of being irremediably non-functioning, there are three major options :

(1) withdrawal of artificial and/or mechanical life-support systems (i.e. non-interference with death);

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(2) administration of pain-relieving drugs which will have the effect, among other effects, of accelerating the death process (i.e. hastening of death)

(3) administration of death-inducing or life-terminating agents (i.e. deliberate action calculated to cause death).

I think it is arguable, says L. Harmon Smith (ETHICS AND THE NEW MEDICINE, p. 167) that options 1 and 2 are now morally licit procedures in the management of terminal or brain-destroyed patients, but that option 3 is not needed if we properly understand and apply the dispensability (i.e. the non-manditorinees) of both extraordinary and ordinary means which are not remedies. The line between options 2 and 3 is a fine one, I know; but it is reinforced by the awareness that medical science and technology have developed many possibilities for which we have not yet developed the ethical wisdom and moral stamina necessary for exercising humanely responsible control.

SOME NORMS : In arriving at a morally discriminating decision, the following norms should be kept in mind.

(1) "A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

(2) Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community; its members are not bound to prolong the agony for a human being.

(3) There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available. In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances."

(4) "I would urge that we promote the idea of benemori, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. 'Bene mori' that is, allowing the patient to die peaceably and in dignity is always justified."

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EUTHANASIA : Etymologically the word means "dying well". But the word has now come to mean "easy dying", for it implies medical intervention to cut short life by causing death. We must distinguish between euthanasia which is claimed as a legal right, and euthanasia as a moral option.

(a) Legal euthanasia: Advocates of euthanasia as a legal right of every citizen can be understood to speak of euthanasia in two senses:

(i) In the strict sense : i.e., "to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death".

(ii) In a wider sense : This would include: (a) to cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.; (b) to cause death, for the sake of society, to a socially dangerous person, and in general to persons who cannot live morally useful lives within society (the so-called 'eugenic deaths', and disposal of useless persons e.g. the aged, mentally retarded etc.)

The judgement on this has been succinctly formulated by Pope Paul VI when he wrote to the International Federation of Catholic Medical Associations: "Without the consent of the person, euthanasia is murder. His consent would make it suicide."

(b) Euthanasia as a moral option : Here it is customary to distinguish between (i) Direct or positive euthanasia: i.e. the rendering of assistance in order to cause death, This can never be allowed. (ii) Indirect or negative euthanasia: i.e. the administration of treatment, e.g. for the alleviation of pain, which has as a side effect the acceleration of death. Here, we could also include the stopping of those procedures which only prolong the process of dying, while they hold out no hope for life. This should better not be called euthanasia at all, and in fact is morally licit.

FINAL SUMMARY

We can summarize all that has been said above, in an organized way, by quoting extensively from a lecture given by Dr. G.B. Giertz at a Ciba Foundation Symposium on ETHICS IN MEDICAL PROGRESS: with special reference to transplantation. He writes: "The subject of euthanasia poses new problems in medical ethics. The central point is whether we can establish the moment when life ceases to have any human value; this is essentially the same central problem as in abortion, although it is then a question of deciding the time when life begins to have human value. Both problems force us to face up to the question of whether man can draw such a boundary that he can disregard the obligation to protect life. There are essentially two possibilities. One is to leave the duty to protect and preserve human life unconditional. Such a view implies that man lacks the

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right to determine the length of life and to judge what is a valueless life and what a valuable one. The second possibility is euthanasia, for which there are strong advocates in Sweden. A professor of practical philosopy asks: "Is the physician's virtuous skill in repairing damaged individuals and sending them back to so-called life, blind or deaf, with grave changes in personality, with poor sight or deprived of the power of locomotion, actually a gain from the aspect of the value of human life"? In this connexion the economic factor has been mentioned. Is it in fact intended that we shall provide the medical services with resources for furnishing life supporting measures for every individual who might qualify for it, even when the prospects of securing a recovery are negligible? Should we not accept that man shall decide what is fit for life and what is not, and direct our resources to the former?

More recently a third factor has entered this discussion, namely the question of the dignity of life and death. My own attitude is that in the treatment of the hopeless case we should try to act so that the patient, in spite of everything, can live as normal a life as possible and is freed from pain as far as possible. Much of our medical effort is concerned with achieving these ends. We choose the path that appears to us to be the wisest from the human and medical aspects, and thus do not limit our consideration to probable survival time. But when shall we give up the struggle? In most cases it is not difficult to decide. So long as we are not convinced that all hope is gone we should as a rule fight with all the means at our disposal. But when we have been able to establish that the end must soon come, then we should take this into account in our action. In this situation death is a natural phenomenon and should be allowed to run its course. The thought that we physicians should be obliged, for instance, to keep a patient alive with a respirator when there is no possibility of recovery, solely to try to prolong his life by perhaps 24 hours, is a terrifying one. It must be regarded as a medical axiom that one should not be obliged in every situation to use all means to prolong life. Such an obligation would rapidly lead to an untenable situation and spell disaster to our hospital organization. The point is that these considerations are purely medical ones - no step is taken with the object of killing the patient. We refrain from treatment because it does not serve any purpose, because it is not in the patient's interest. I cannot regard this as killing by medical means: death has already won, despite the fight we have put up, and we must accept the fact. Only the recognition of this limit can enable us to solve the problem that for many has made the thought of death an agonizing one - the fear of an artificial prolongation of life when it has already been bereft of all its potentialities.

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ON DEATH AND DYING

1. The Doctor face to face with death : Death is a frightful, fearful happening, which, we are convinced, "happens to other people", (Franceis Mauriac). Yet it is something the doctor has to face routinely in the course of his practice. He must face not only the dying patient but also his relatives to whom he has to break the news of the impending end. The patient expects his doctor to stand by him till the end, and in an existential way will ask the doctor about the odds for his life or demise. And, inescapably, the queries of the patient will become the question the doctor must ask himself: 'what is death'? If death is a big problem in the life of the doctor himself, if it is viewed as a frightening, horrible, taboo topic, he will never be able to face it helpfully with his patients. He might hope they will not bring it up, and would probably talk about other trivial things.

The Physician stands always on the side of life. He must wage the battle against death with all the strength of his competence and commitment. He must inspire in his patient the will to live and encourage the hope of recovering health. But if to live is to be free, then the highest point of personal freedom is the courage to face peacefully the prospect of imminent death. If the doctor considers the patient's death as the enemy to his profession, death as a professional battle lost, then in his desperate struggle against death he will not help the patient to serenity and balance, strength and effective personal freedom in the face of death. As a famous physician writes: "Not only for the dying patient but also for the doctor, does a strong faith generate an intensification of freedom. It allows the physician a full commitment to life without that obsession which considers death as the greatest of evils, since we consider death as belonging to the fulness of life. The free acceptance of death is the only real chance to get out of that death which seems to destroy all our strength, a last opportunity to assert our freedom." It should therefore be the doctor's endeavour to assist the patient in achieving a peaceful death. Pain should be relieved as much as possible, but with the main objective of ensuring freedom and peace. The fear of death, it's greatest terror, should be defeated. Only then can freedom mature.

2. The Meaning of Death : In acquiring correct attitudes, the doctor must ask himself, and answer satisfactorily, the question: "What is the meaning of death?" Below are given a few points as guidelines.

   (a) Death is something which happens to a person. Whereas death can be considered from different angles - cytological, physiological, philosophical, theological - each person apprehends his/her death as an uniquely expressive event. It is not 'a machine coming to a stop', nor 'a bit more troublesome form of human waste' nor 'an affront to our inalienable right to life, liberty and the pursuit of happiness' (Toynbee), but an intensely personal thing - a stage in living. The process of dying is in reality the art of living meaningfully in and through the process of dying. "Death belongs to life as birth does; the walk is in the raising of the foot as in the laying it down." (Tagore).

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(b) Death is a real factor in the meaningfulness of life. In the face of death, says Viktor Frankl, as absolute finis to our future and boundary to our possibilities, we are under the imperative of utilizing our lifetimes to the utmost, not letting the singular opportunities - whose 'finite' sum constitutes the whole of life - pass by unused.

(c) Death, for the believer, is also a significant religious event : It is, as it were, the occasion on which we ratify the fundamental options we make in life. Those who, for example, believe in Jesus Christ, and in his passion, death and resurrection, as a salvific event, gain a new vision of death. Christ transforms death into the greatest manifestation of trust in the Father and love for all mankind. For the Christian, death opens on to life eternal. Every doctor should try to be cognizant of the hope and faith of his believing patients, the better to help them to face the prospect of death with equanimity.

3. The Moment of Death : In view of organ transplantation, this question has acquired special significance. After all, a person dying is still a person living, and he keeps his elimentary human rights up to the moment when life becomes extinct.

In short, the principle that brain death is synonymous with the death of the patient (or death of the person) has found universal agreement. A Harvard University team that studied this question in depth gave the following criteria: "It stated that in order for brain death to be designated the subject should be in deep and irreversible coma; manifest a total un-awareness to external painful stimuli; have no spontaneous muscular movements or responses to external stimuli; have no respirations when not in resuscitator; have no elicitable reflexes; have pupils fixed, dilated, and unresponsive to light; and have an isollectric EEG (flat EEG), with the foregoing characteristics having been maintained over a period of 24 hours." (Archives of Internal Medicine, 124 - August 1969 - p. 226-227)

4. THE PROBLEM OF THE PROLONGATION OF LIFE AND EUTHANASIA.

The right to live humanly implies the right to die humanly , i.e. with dignity and in freedom. Does this mean that the patient has the right to end his life or the doctor to assist him in doing so? In a recent document, the American Hospital Association approved a 12-point Declaration of Rights of Hospital Patients, which grants to the patient the right, among others, "to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of his action". This implies that an adult patient with no prognosis for recovery has a right to die without medical therapy. The point is: would this "right to die" justify the patient in asking the doctor to end his life, or justify the doctor in presuming this consent and acting in such a way as to cause death ?

THREE POSSIBILITIES : In the management of terminally ill patients, or patients whose brain has suffered massive destruction to the extent of being irremediably non-functioning, there are three major options :

(1) withdrawal of artificial and/or mechanical life-support systems (i.e. non-interference with death);

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(2) administration of pain-relieving drugs which will have the effect, among other effects, of accelerating the death process (i.e. hastening of death)

(3) administration of death-inducing or life-terminating agents (i.e. deliberate action calculated to cause death).

I think it is arguable, says L. Harmon Smith (ETHICS AND THE NEW MEDICINE, p. 167) that options 1 and 2 are now morally licit procedures in the management of terminal or brain-destroyed patients, but that option 3 is not needed if we properly understand and apply the dispensability (i.e. the non-manditorinees) of both extraordinary and ordinary means which are not remedies. The line between options 2 and 3 is a fine one, I know; but it is reinforced by the awareness that medical science and technology have developed many possibilities for which we have not yet developed the ethical wisdom and moral stamina necessary for exercising humanely responsible control.

<u>SOME NORMS</u> : In arriving at a morally discriminating decision, the following norms should be kept in mind.

(1) "A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

(2) Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community; its members are not bound to prolong the agony for a human being.

(3) There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available. In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances."

(4) "I would urge that we promote the idea of benemori, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. 'Bene mori' that is, allowing the patient to die peaceably and in dignity is always justified."

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EUTHANASIA : Etymologically the word means "dying well". But the word has now come to mean "easy dying", for it implies medical intervention to cut short life by causing death. We must distinguish between euthanasia which is claimed as a legal right, and euthanasia as a moral option.

(a) Legal euthanasia: Advocates of euthanasia as a legal right of every citizen can be understood to speak of euthanasia in two senses:

(i) In the strict sense : i.e., "to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death".

(ii) In a wider sense : This would include: (a) to cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.; (b) to cause death, for the sake of society, to a socially dangerous person, and in general to persons who cannot live morally useful lives within society (the so-called 'eugenic deaths', and disposal of useless persons e.g. the aged, mentally retarded etc.)

The judgement on this has been succinctly formulated by Pope Paul VI when he wrote to the International Federation of Catholic Medical Associations: "Without the consent of the person, euthanasia is murder. His consent would make it suicide."

(b) Euthanasia as a moral option : Here it is customary to distinguish between (i) Direct or positive euthanasia: i.e. the rendering of assistance in order to cause death, This can never be allowed. (ii) Indirect or negative euthanasia: i.e. the administration of treatment, e.g. for the alleviation of pain, which has as a side effect the acceleration of death. Here, we could also include the stopping of those procedures which only prolong the process of dying, while they hold out no hope for life. This should better not be called euthanasia at all, and in fact is morally licit.

FINAL SUMMARY

We can summarize all that has been said above, in an organized way, by quoting extensively from a lecture given by Dr. G.B. Giertz at a Ciba Foundation Symposium on ETHICS IN MEDICAL PROGRESS: with special reference to transplantation. He writes: "The subject of euthanasia poses new problems in medical ethics. The central point is whether we can establish the moment when life ceases to have any human value; this is essentially the same central problem as in abortion, although it is then a question of deciding the time when life begins to have human value. Both problems force us to face up to the question of whether man can draw such a boundary that he can disregard the obligation to protect life. There are essentially two possibilities. One is to leave the duty to protect and preserve human life unconditional. Such a view implies that man lacks the

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right to determine the length of life and to judge what is a valueless life and what a valuable one. The second possibility is euthanasia, for which there are strong advocates in Sweden. A professor of practical philosopy asks: "Is the physician's virtuous skill in repairing damaged individuals and sending them back to so-called life, blind or deaf, with grave changes in personality, with poor sight or deprived of the power of locomotion, actually a gain from the aspect of the value of human life"? In this connexion the economic factor has been mentioned. Is it in fact intended that we shall provide the medical services with resources for furnishing life supporting measures for every individual who might qualify for it, even when the prospects of securing a recovery are negligible? Should we not accept that man shall decide what is fit for life and what is not, and direct our resources to the former?

More recently a third factor has entered this discussion, namely the question of the dignity of life and death. My own attitude is that in the treatment of the hopeless case we should try to act so that the patient, in spite of everything, can live as normal a life as possible and is freed from pain as far as possible. Much of our medical effort is concerned with achieving these ends. We choose the path that appears to us to be the wisest from the human and medical aspects, and thus do not limit our consideration to probable survival time. But when shall we give up the struggle? In most cases it is not difficult to decide. So long as we are not convinced that all hope is gone we should as a rule fight with all the means at our disposal. But when we have been able to establish that the end must soon come, then we should take this into account in our action. In this situation death is a natural phenomenon and should be allowed to run its course. The thought that we physicians should be obliged, for instance, to keep a patient alive with a respirator when there is no possibility of recovery, solely to try to prolong his life by perhaps 24 hours, is a terrifying one. It must be regarded as a medical axiom that one should not be obliged in every situation to use all means to prolong life. Such an obligation would rapidly lead to an untenable situation and spell disaster to our hospital organization. The point is that these considerations are purely medical ones - no step is taken with the object of killing the patient. We refrain from treatment because it does not serve any purpose, because it is not in the patient's interest. I cannot regard this as killing by medical means: death has already won, despite the fight we have put up, and we must accept the fact. Only the recognition of this limit can enable us to solve the problem that for many has made the thought of death an agonizing one - the fear of an artificial prolongation of life when it has already been bereft of all its potentialities.

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Topics dealt with in the present course of Medical Ethics

I. INTRODUCTORY LECTURES:

1. What is Medical Ethics? (vs. medical etiquette)
   Basic principles of Medical Ethics.
2. The Concept of Health - a total perspective.
3. Health care priorities and social justice.
4. The Doctor -patient relationship
   - medical responsibility to the individual and community.
   - the doctor vis-a-vis social legislation
   - the medical secret.

II. PROBLEMS CONNECTED WITH THE BEGINNING OF LIFE

5. Artificial Insemination
6. Genetic engineering
7. Abortion

III. PROBLEMS CONNECTED WITH SEXUALITY AND MARRIAGE

8. Meaning of human sexuality
9. Contraception
   a) Motives and methods
   b) Morality
10. Abnormal~~ity~~ sexuality (e.g. homosexuality)
11. Masturbation
12. Marriage counselling (e.g. VD of patient and obligations to partner; sterility; impotence)

IV. PROBLEMS CONNECTED WITH THE INTEGRITY OF THE BODY AND OF THE PERSON.

13. Mutilitation, sterilisation
14. Psychosurgery, psychotherapy, narcoanalysis and hypnotism.
15. Experimentation on human beings

V. PROBLEMS CONNECTED WITH THE END OF LIFE.

16. The meaning of Death
17. Telling the truth to the patient
18. Prolongation of life and the problem of Euthanasia.

VI. SPECIAL SECTION.

19. Alcoholism and drug addiction
20. Transplantation (Blood transfusion & haemodialysis)

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MEDICAL TECHNOLOGY - ETHICAL ISSUES

- Anil Pilgaokar -

The practice of medicine by its very nature (a) invades the privacy of individuals (patients) and (b) is vulnerable to what may be best termed "rationalized misuse/illuse potential." It is in this context that ethical facets of Medical Practice become very important. "Technology" (described as the "science of industrial arts" - Consise Oxford Dictionary) by its very genesis lends itself to commercial exploitation. It is in this light that ethical issues of medical technology become of paramount importance but alas this is a neglected subject in the medical circles. It is with this at the back of the mind that we felt that it would be of pertinence that there is at least some sort of debate and discussion on the subject and hence this paper. It must be clarified at the outset that we are alive to the rather dismal prospects of putting before you a comprehensive paper before you but then that is neither our claim nor our aim to do so. There are limitations of data and more importantly our own limitations which prevent us from taking any firm position(s) in respect of many topics covered in the paper, but then it is our hope that vigourous (rigourous) deliberations at the MFC meeting would be helpful in (a) clarifying the grey areas on the one hand and (b) taking up some position(s) in respect of many aspects discussed in the paper; (which primarily is concerned with raising some questions for discussion).

Admittedly medical technology is a broad term and it would be purposeless to dwelve on every technology concerned with the practice of medicine; for that matter even commonplace 'injections' could be concieved as 'technology, and it would be quite pointless to discuss the ethical aspects of injections here. Rather it is our intention to restrict ourselves to newer sophisticated and/or pervasive medical technologies. In very crude terms, for the purpose of this paper we shall ignore the "first generation technologies" (to burrow the current 'in' expression) like say X-ray machines, and devote the discussion to "higher generation technologies" like CAT-scan or PET-scan.

Grouping/Catagorization of Technologies:

In our surrvey of literature we have not come across any grouping or catagorization of the various technologies harnessed in medical practice: but for the purposes of this paper it is important to device one and so even at the risk of being challenged we have resorted to the following classification:

(i) Function replacement medical technologies eg. Heart-Lung machines or say renal dialysis units; cardiac pace-makers etc.

(ii) Investigational-aid medical technologies like CAT-scan: sonography; echo-cardiography; and its sub-class (ii-a) "Investigational-aid extendable (in some cases) to curative." medical technologies like some endoscopic instruments.

(iii) "Control technologies" like contraceptives, vaccines, and artificial life-support technologies, and of course genetic engineering and sex-preselection technologies.

Each as a class would have its own ethical considerations in addition to general ethical considerations. A priori, the above classification suggests a need for increasing stringency in ethical considerations with each class of the medical technology. Whereas the benifit: risk as also the cost: benefit evaluations vis-a-vis respective populations must form a base for assessing the relevence (in ethical terms) in all the three classes of technologies but it is evident that in the first class, the ethical considerations would mainly relate to 'operational' part i.e. use; mis-use; denial of use as also the fees for services etc. The ethical questions in this class mostly relate to the individual patient and the institution (investigating centre) policies. In the next class (ii), the ethical questions - all ethical questions relevent to the previous class are indeed pertinent but in addition, because of the enormous costs of some of the instruments involved ethical considerations in National priorities also must form important facets as many of the instruments lock up and siphon significant monetory resources, and thereby quite often affect (adversely) other medical facilities by depriving funds for these. In the last class, even more wider questions relating to demographic, individual rights vs rights of societies, right (?) to manipulate human systems and forms etc. could figure.

(i) Function replacement technologies: Admittedly most of these technologies are indeed 'life-saving' in critical conditions. But when the question such as whose life? become appearent (as in many cases in our setting do) then ethical issues do arise and these need to be debated in full measure. We shall take just two illustrations to initiate the debate.

(a) It is well-known that in a renal dialysis unit priority for dialysis service is given to acute cases rather than chronic renal failures. Again there is a long waiting list for routine dialysis of chronic renal failure patients (who have to be placed in a queue system because of the paucity of dialysis units. Even so when "J.P." needed dialysis (Jaslog Hospital) he got precedence over others. With all regards for the noble man, the question of whether life of other citizen is worth anyless needs to be taken up.

Again, the dialysis serves as a temparory respite until the organ teransplant arrangements are available, and it is at this juncture that further ethical issues arise. Should kindney of a young person be transfered to older person? The obvious answer is No. Yet one finds that kindney from a young woman (16) being transplanted on to MGR - knowing that the leader was close to his grave.

The "organ trade" racket with the conivance of the medical profession has been highlighted in lay press and yet the ethical questions have not been raised in relevant bodies.

It must be conceled that the examples quoted above, are not strictly ethical issues of medical technology, rather they are issues related to 'medical practice'. All the same these are so intimately connected with the technology usage that the mention made here would not be totally out of place.

(b) Cardiac pace - makers are fairly widely used in our country. And for harnessing this technology Intensive Cardiac Care Units (ICCU) are essential. The usefulness of these units is widely known and acknowledged. What is not generally appreciated is that in our settings is that a proliferation of such units could actually impede the quality of service (medical service) in other faculties of the hospital/ institution. A bed in ICCU could cost (to the institution)

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some 100 times more than the bed in say a general ward (of a public hospital). With relative crunches on the budget of the hospital, the pinch for resources is felt by other facilities. Any keen observer, who has observ the "progress" of some of our prëmier public hospital in last two decades, could not have failed to notice that with the advent of super-specialities (like ICCU, Artificial Kindly Units and the like), there is a steady degradation in the facilities in other departments. So we have a situation where the best of the facilities would be available in these highly specialized units and at the same time there would be acute dearth of common requirements like cotton, lint and linen in the general wards of the same hospital.

Even at the cost of increasing the length of the paper let us labour over this point a little more. It would not require statistical figures to state that the incedence of tuberculosis in the city of Bombay far, far exceeds that of CVDs. Dr. Amar Jesani (Economic & Political Weekly, Sept.24, 1988) has pointed out that the deaths due to TB in the city have increased over the years thus emphasising the increased requirement of hospital beds for TB in the city, but these have in fact been reduced by Bombay Municipal Corporation (paucity of funds) in the only hospital for tuberculosis in the city of Bombay; whereas there is a spurt in the ICCU beds in the city. (And mind you the ICCU beds cost some 100 times more) The number of ICCU beds in the city (in both public and private hospitals together) are some 30 to 35% that of the beds in the TB hospital.

Is this due to class biases ? CVD is a rich man's diseases and TB is a poor man's diseases. Is it 'ethical' to permit spurt in ICCU beds ?. At the cost of TB beds ?

(ii) Investigational-aid medical technolocies:- In this group there are technologies that 'affordable' only to institutions as for example CAT-scan instrument and there the ones like sonography (ultrasound) which can be found with individuals too. What is peculiar, atleast as far as Bombay is considered is that none of the public hospitals have these as of today. And this brings out two possible reasons for this viz (a) the aquisition of these instruments is primarily for 'marketing' reasons - marketing of 'image' of the institution and (b) the law of diminishing returns impedes the aquisition of these instruments in public hospital i.e. the additional benefit in investigations with the aquisition of these instruments is not commensurate with the hugh cost of aquisition, operation and maintenence of the instrument.

It is true that public hospitals have little access to recovery of costs from the patients (even when these have resorted to collecting partial fees from the patients (in Maharashtra). But in private hospitals fees are levied for services, it would be unthinkable to operate these instruments (CAT-scan) if these are to be used solely used in well selected cases only. This is because the capital investment (around Rs.30 lacs) and allocation for operation and maintenence (another Rs.30 lacs) would work out in annual interest of Rs.10 to 12 lacs, which would have to be acrued from the patients, (i.e. Rs.1 lac per month). And considering that the time required for 'processing' a patient is 2 hrs and an 8 hr working period, it

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would mean to break even this Rs. 1 lac would have to be recovered from 120 patients or Rs.833/- per patient.

The question that one needs to consider is that would there be 120 truely well selected cases for such scan in a month, every month, every year ? If the answer is NO then it follows that patients who do not require such an investigation would also be enlisted for such investigation - which seems to be the case indeed. How does this stand on ethical grounds ? How does one ensure that such trend is checked ? reversed ? Could there be a well laid down norms for selecting cases ? Could there be an audit of such investigations ? Who would conduct such an audit ? These and many other questions will need to be answered.

Sonography : Ultrasound technology : This has been the domain of obstetricians and many obstetricians perhaps aquire this instrument for 'image' purposes. The premise that the technology is 'safe' (is it conclusively proved ?) has led to rampant ill-use or mis-use. Widespread (though unconfirmed) reports have indicated that this technology is used to detect pregnancy when cheaper, more accurate and non-invasive pregnancy tests are freely available. One reason behind this is to enable to charge fees (ususally exhorbitant) for the investigation. How ethical is this ? What does one do to prevent this ? What are the situations when use of this technology is rational ? Can there be an audit?

(iii) Control technologies :- These are perhaps the most 'impactful' and controversial technologies, and ethical as also philosophical must be discussed.

Contraceptives technology : There has been a shift in technology (ies) 'progressing' "user-safety" to "contraceptive duration of action" (from condoms & diapharms to 'implants'); there is a shift from "user-control" (condoms & diaphrams) to "doctor-control" (implants). The shift has been from birth control to population control. Is this ethical ?

In the case of doctor-control (and therefore state control) contraceptive if there is a contraception failure should it not merit compensation ? Is consent necessary ? imminent ? Is it sought to ?
The question also arises of 'doctored' results of field trials ? Should there be a third party audit of the field trials, particularly since there is an obsession to pushing these technologies.

Vaccines : These technologies being a part of Preventive Medicine are state mediated and at general population level some questions need to be raised. Is consent a necessary pre-requisit before vaccination ? In the event of vaccine failure should the patient not be compensated ? Can vaccination be forced in epidemics ?

Sex-preselection / selective foeticide : Sex-determination and selective foeticide and Sex-preselection technologies

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are the ones which have discriminitory and demographic-upset potential of the worst kind and yet these technologies are vigourously persued. In extremely small number of cases where a particular sex foetus could jeopardize the life of the pregnant woman can these be justified if at all. Even so there are no laid down ethical codes in respect of these at all. Apart from catering to individual passion for a particular sex of spring, scientific ego of achieving control over life processes, and a political handle to manipulate sex composition of a population, these technologies have little to offer to mankind. The basic premise in medical research is to improve the quality of human sustenence. These technologies have very little to offer in that direction (except perhaps cases mentioned above.) But they do have an enormously large adverse potential.

Should such technologies be allowed to be harnessed in the country ? Should not the medical comunity decrey these technologies on ethical grounds ?

Genetic Engineering : These technologies can have extremely widespread manifestations and carry with them dichotomous repurcussions. It is with this at the back of mind that there needs to be an extensive debate on the merits and demerits of these technologies to work out a rigid code of procedures.

The justifiable purpose of genetic engineering (we are restricting ourselves only to medical aspects of genetic engineering only) can be to rectify genetic aberrations (note the avoidence of the word abnormality) which can have disasterous or agonizing consequence and nothing more.

However as things stand today the commonly persued (and commonly percieved) goal of the technology is to rectify genetic abnormalities and improve the quality (of genes ?). Just what is abnormal? What is improvement in quality of genes ? On this there is no final word. What is more it is unlikely that there could be any final word on this. Allow us to elaborate this further.

Genetic aberrations like Down's syndrome; inborn errors of metabolism; juvenile diabetes (?) can have disasterous consequences and genetic rectification could possibly avoid these con-sequences and perhaps this technology could have credence in these areas. But say, if a person has six fingers on his/her hand, there is no reason to label him/her as ABNORMAL just because he/she does not conform to the commonly percieved frame of reference, since there is no physiological/physical agony or distress emanating. This line of argument can be extended to ridiculous but effective extent thus.

Blond hair, blue eyes and fair skin is normal to certain populations and a dark skinned, dark eyed and black haired person in this population would be ABNORMAL would genetic engineering experts like to 'improve' (?) this individual to fair skin, blue eyed and blond haired person. Decades

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earlier an 'engineer' attempted to do a similar exercise; his name was Hitler and his goal was called Fascism.

Can genetic engineering lead to camouflaged Fascism ? What are the ethical and philosophical positions one takes on genetic engineering ?

Life support technologies employed in lengthing 'vegitative' forms of human (inhuman) existence : Prolonging 'life' with total disregard to QUALITY of life is not uncommon these days Is this ethical ? Is it ethical to perpetuate incapacitation ? What is the position one takes on this issue ?

Research What are (should be) the priorities in research for developing technologies ? Who takes the decisions ? Whose needs (what needs) are given importance ? These are the crucial questions that need to be answered. The situation existing today is not one where 'independent' medical scientists engaged themselves in research and lead to discoveries. Today he or she is either employed directly by commercial corporation or if not is his research effort is heavily financed (and therefore controlled) by commercial corporations (for profits) in the name of 'service to humanity'. The commercial priorities invariably leed to secrecy, unethical conduct of research (witness the contraceptive research) and 'doctored results' and when scientific expertise and commercial power combine (as it is today) all this become ever so easy and free from challenge.

If there are strict laid down norms for drug research, why can their not be similar rigidity of conditions in research for developing technologies ? The question of consent in research & in practice is a virtual farce. Ethics of research and practice is evident by its absence. Use of technologies to serve defence medicine - whether right or otherwise - can be a matter of debate in United States but in India (today) does it have any place ?

Fears :

There can be no conclusions to a paper of this sort only FEARS. When one overviews the situations one distinctly gets the impression that the entire persuit is one of concentration of power, centralization of power - Medical Power; Contraceptive technology is shifting from end-user control to doctor-institution control. High priced instruments are phasing investigation pathology from individual doctor to institution. Function replacement technology vulnerably chains the patient to medical establishment. Artificial Life Support systems virtually confines the patient to institutions with very little else. Through selective foeticide and sex-preselection technology, medical establishment aquires a manipulative potential and this is further compounded with the emergence and proliferation of genetic engineering. We have had political leaders controlling populations, we have had religious leaders controlling populations. Will the Medical man : Commerce man combine also jump into the arena ?

NOTE : We appeal to your generosity and pardon us for stretching the point to ridiculous extent but believe us the intention is only to provoke discussion.

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MP-2.

01.04.1999 (Thursday)			
9.30 – 10.00 am	Session 6	Summary of previous day's proceedings	Dr. V.L. Pattankar Dr. T.K. Nagabhushanam
10 – 11.00 am	Session 7	Teaching/Learning Ethics in Medical Education: Problems; opportunities	Dr. C.M. Francis
11 – 11.15 am	Coffee		
11.15 – 12.15 pm	Session 8	Ethics Teaching Programme in St. John's Medical College, Bangalore.	Dr. Prem Pais Dr. G.D. Ravindran, Dr. Sanjiv Lewin Dr. Fr. Kalam.
12.15 – 1.15 pm	Session 9	Group work on Evolving Action Plan for implementing RGUHS Syllabus on Ethics – Who, When, Where, How?	
1.15 – 2 pm	Lunch		
2 – 3.15 pm	Session 10	Plenary: Group Reports Discussions	Chairperson: Dr. C.M. Francis
3.15 – 3.30 pm	Tea		
3.30 – 4.30 pm	Session 11	Evolving a consensus. Recommendations; Wrap-up	Chairperson: Dr. (Mrs.) S. Kantha.

SECTION C : APPENDICES

Appendix – C-1

Raja Gandhi University of Health Sciences, Karnataka, Bangalore.

Workshop on Medical Ethics in Medical Education
PROGRAMME

31.03.1999 (Wednesday)			
10.15 a.m.	Session 1	Inauguration	Dr. (Mrs. S. Kantha, Vice Chancellor, RGUHS, Bangalore.
		Introductions Workshop objectives	Dr. D.K. Srinivasa
11 – 11.15 am	Coffee		
11.15 – 12.30 pm	Session 2a	Keynote inputs a) Medical Ethics & Health Care in India	Chairperson : Dr. G.V.Satyavati (retired DG, ICMR) Dr. Madhava Menon
	Session 2b	b) Medical Ethics – An Indian Perspective	Chairperson: Dr. S. V. Joga Rao, NLSIU, Dr. K.H. Krishnamurthy
12.30 – 1.15 pm	Session 3	International Declarations; Codes of conduct; Principles of Medical Ethics.	Dr. D.K. Srinivas
1.15 – 2.00 pm	Lunch		
2 – 3.30 pm	Session 4	Ethical issues related to: Patient care Public Health & Rights to Health Research	Dr. Om Prakash Dr. Thelma Narayan Dr. Vasantha Muthuswamy
3.30 – 3.45 pm	Tea		
3.45 – 4.45 pm	Session 5	Group Discussion on: 1. Alternative Systems of Medicine 2. Assisted Reproductive Technologies 3. Genetics and medical ethics 4. Organ transplantation 5. Patients' rights	Resource Persons 1. Dr. Jayaprakash – Group 1 2. Dr. Gomathi Narayan – Group 2 3. Dr. Sayee Rajangam-Group 3 4. Dr. H.S. Ballal – Group 4 5. Dr. C.M. Francis – Group 5
4.45 – 5.30 pm	Session 5 Contd.	Plenary; Reports; Discussions	Chairperson

gives the conclusive comments to end the hour of discussion. Thought-provoking posters are displayed all over the campus before the meeting to arouse interest.

TABLE III
TOPICS FOR THE CLINICAL ETHICS MEETING FOR INTERNS

- Ethical work up of a case
- Truth and confidentiality
- Ethics at the beginning of life
- Ethics at the end of life
- Resource allocation
- Transplant ethics
- Pharmaceutical ethics
- Doctor-patient relationship
- Doctor-doctor relationship

Debates

When contemporary issues arise, they are used to debate ethical issues. Topics used for such debates between interns guided by faculty, included in the past: genetic cloning, abortions, euthanasia, liver transplants and kidney sales.

How is this teaching evaluated?

At the end of the seventh term, an examination, which includes an essay and a situation analysis, is held. The best essay is awarded a college prize in clinical ethics on Graduation Day. The interns log book contains essential skills to be completed through the course. Included in this log book is essential ethical skills and also the need for 50% attendance at Interns ethical conferences before an internship completion certificate is awarded.

Problem encountered

There is a lack of a systematic collection of Indian court rulings involving medical issues. There is also little available on the application of Indian philosophical thought to problems of medical ethics. There also exist problems of skewed role models and the difficulty in sustaining an interest among staff and students in attending / participating in medical ethics programs.

Table II
CURRICULUM ON MEDICAL ETHICS FOR UNDERGRADUATES

- Introduction to medical ethics
- Definition on medical ethics
- Approaches to medical ethics
- Perspectives to medical ethics
- Ethics of the individual
- The ethics of human life
- The family and society in medical ethics
- Death and dying
- Professional ethics
- Research ethics
- Ethical work-up of cases
- Special situations in Christian bioethics.

What methods of teaching are used in St. John's?

Method	Phase
Lectures Group Discussions Role plays Video Cassettes Case studies	Pre-clinical/Clinical phase

In addition,

Method	Phase
Case presentations/Discussions Debates Role Plays	Internship

Role Plays:

Appropriate topics, for example, Resource Allocation, Ethics are discussed using students playing roles of a hospital administrator, super-specialist, primary physician and patient. Each player gives his/her reasons for decisions taken regarding resources allocation. Students are then sensitized to ethical issues pertinent to the topic.

Intern Case Presentation

The weekly hospital clinical conferences are chosen for the internship clinical ethics teaching program. Once in two months, an intern presents an actual hospital case with an ethical conflict. He or she presents to the audience the ethical issues in conflict, solves the dilemma or atleast raises issues. A faculty member makes a brief presentation on one major ethical issue being discussed. The interns in the audience are encouraged to actively participate in discussion and arguments for and against various options to solve the conflict. A faculty member from the core group then conducted in the institute. Teaching of medical ethics is by members of the Department of Clinical Ethics headed by the Professor of Medical Ethics, who is trained in Psychology and religious studies. Other members include members of the clergy and medical faculty members interested in teaching ethics. Together they form the core teams.

In the pre-clinical years, value classes are conducted by student counsellors, pastoral care members and medical faculty. During the clinical years, clinical ethics is taught by the professor of Ethics and medical faculty of the core team. As interns, the medical faculty of the core team involve other medical faculty, lawyers, social activists and lay persons in conducting ethical case discussions. The approach is multidisciplinary and reveals the relevance of clinical ethics in clinical medicine.

Table I

TOPICS FOR VALUE CLASSES IN THE PRE-CLINICAL YEARS

- Adjustment
- Knowing myself
- My religious beliefs
- My value system
- Concern for the needy
- The need for each other
- Sharing
- Meaning to life
- Character and temperament
- Love.

When does St. John's teach Medical Ethics?

There is a conscious effort to inculcate ethical values throughout the undergraduate training program. A dress code and strict attendance is adhered to throughout the course. Internal examinations are strictly marked and internship includes a three months residential rural posting. Sensitization to rural needs is stressed upon through the two Rural Orientation programs held for all students, one during the first year and the second, halfway through the course. During the initial preclinical years, value classes are held. Formal clinical ethics classes are held during the third year (fifth semester) and fourth year (seventh semester).

Formal undergraduate medical ethics teaching involves 40 hours of teaching. This excludes the two Rural Orientation Programs and the bimonthly Hospital conferences on Ethics during Internship.

B5 - THE ST. JOHN's MEDICAL COLLEGE ETHICS COURSE*

TEACHING MEDICAL ETHICS**

Medical Ethics should be an important part of a under-graduate medical curriculum. It should not be left to a "laissez-faire" process of osmosis from teacher to students. St. John's Medical College, Bangalore, was established in 1963. It is the only catholic medical college in the country and has a 60 undergraduate student intake per year.

Why does St. John's teach Medical Ethics?

Since 1963, St. John's has had a Department of Medical Ethics which has grown to include a professor of Medical Ethics, Clergy and Medical faculty. Apart from regular medical ethics teaching, St. John's also has a value paper as a part of its All India entrance examination. The reason for the value paper is an attempt to screen for appropriate human values which would make a 'good' human doctor. In addition, a further analysis of these values occurs during the vigorous four day interviews and discussions before admittance to the undergraduate course. This entrance procedure and medical ethics teaching is to fulfil two of the objectives set by St. John's for their undergraduate training program. The first objective is that graduates are trained and oriented towards health care in a rural and underserved area. The second objective requires the training to assist students acquire an exemplary steadfastness to principles and moral values; to a life of honesty and integrity; and also to develop respect for human life from time of inception to its end.

What does this teaching of medical ethics hope to achieve?

The team at St. John's is clear that they can neither create a person of sound moral character nor indoctrinate a person. The stress is on sensitizing the students to examine and affirm personal values and recognize ethical aspects of the medical profession. There is also an attempt to impart moral, social and legal knowledge, and, teach skills of clinical analysis enabling the utilization of this in decision making. This teaching is directed towards producing a young doctor with all human values of a 'good' doctor.

Who teaches ethics in St. John's?

St. John's has a Pastoral Care Department, a Hospital Ethics Committee, Research Ethics Committee and a Department of Clinical Ethics. The Pastoral Care Department takes care of the spiritual needs of all staff and patients in the hospital. The Hospital Ethics Committee comprises the Medical Superintendent, HospitalAdministrator and three other faculty including members of the Medical Ethics team. They decide on ethical issues referred to them by clinical teams. The Research Ethics committee studies and gives ethical clearance to all research

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*Dr. Prem Pais, Dr. Sanjiv Lewin, Dr. Fr. Kalam, Dr. G.D. Ravindran.

** This is a compilation of all the four short presentations by the St. John's Medical College Ethics Course team - integrated into one article.

In our country, the Indian Council for Medical Research gave in 1980, detailed guidelines on research and experiments in human beings. It is being revised and a modified code known as ICMR code would be issued soon.

As registered medical practitioners, we are also bound by Code of Medical Ethics of the Indian Medical Council Act, 1956, and some of the general principles of ethics apply as well.

Principles of Ethics

Medical Ethics is part of general ethics. Ethics is derived from 'ethos'. It deals with the right conduct. It is a level of thinking and reflection prior to action. It seeks to answer two fundamental actions: (a) What I ought to do? And (b) How I ought to be? It helps in distinction between what is considered as right or wrong at a given time in a given place, with the moral consequences of the action.

Every profession has an ethical code. It assures members of profession and the public a standard of professional relationships. The code defines norms and serves as a guide. Professionals are expected to adhere. It is different from legislation.

A. Respect for Persons

- Autonomy respecting, Choices & Wishes of competent individuals.
- Protection of the Vulnerable.
- Paternalism

B. ***Beneficence*** : Promoting welfare of others

C. ***Non maleficence***: Avoiding needless risk, if inevitable minimise risk.

D. ***Justice***: Giving what they are entitled to. Giving according to: need, contribution and efforts.

E. ***Utility*** : Producing the greatest possible balance of value over disvalue.

F. ***Fidelity*** : Principle of Institutional arrangement. Principle of Compliance.

Eg.: Keeping promise with funding agency – All procedures required are complied with and all institutional arrangements required to be made are duly made in a bonafide manner. Using funds as stipulated. Ensuring research reports, materials and data connected with the research are duly preserved and archived.

Rules of Biomedical ethics

A. Veracity

Telling truth and not deceiving others.

B4 – ETHICAL CODES IN MEDICAL PRACTICE AND BIO MEDICAL RESEARCH

Dr. D.K. Srinivas

Introduction

Biomedical Scientific Progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research a fundamental distinction must be made between medical research in which the aim is essentially diagnostic or therapeutic for a patient (clinical research) and medical research the essential object of which is purely scientific (Non-clinical Biomedical Research) without direct diagnostic or therapeutic value to person subject to the research.

Special caution must be exercised in the conduct of research which may affect the environment and welfare of animals used for research must be respected.

This paper will mainly deal with ethical codes related to medical practice and biomedical research in human subjects, and briefly on guidelines for care and use of animals in scientific research.

Background

Research on human beings is regulated by international and national codes. After the second World War (1939-45), there was concern about the use of human subjects for medical research. Nazi Physicians were tried in Nuremberg for cruel experiments on prisoners, mentally retarded persons and those held in concentration camps. The first international declaration was the ***Nuremberg Code*** of 1947.

In 1964, the International Organisation of Medical Sciences (CIOMS) and the World Medical association formulated the ***Declaration of Helsinki***. It has been reviewed from time to time and modified by the World Medical Assembly in 1975, 1983 and 1989.

In 1966, the International Covenant on Civil and Political Rights specially stated, among other things, "no one shall be subjected to without his consent to medical or scientific treatment".

In 1982, the World Health Organisation and CIOMS, proposed international guidelines, and in 1993 the CIOMS issued International ethical guidelines for biomedical Research involving Human subjects.

Over the years various countries have also drawn 'national codes' based on the international codes and universal principles.

7. **Children**
    - Age to consent to treatment
    - Parental/Child/Clinician conflict

8. **Mental disorders and disabilities**
    - Detention and treatment without consent
    - Conflicts of interests
        - patient, family, community.

9. **Life, death, dying and killing**
    - Life prolonging treatment
    - Life shortening palliatives
    - Transplantation
    - Death certification

10. **Duties of doctors**
    - Public expectation of medicine
    - Teamwork
    - GMC and professional regulation
    - Clinical mistakes

11. **Resource allocation**
    - "Rationing"
    - Equitable health care
    - Needs, utility, efficiency

12. **Rights**
    - Rights and links with moral and professional duties
    - Concepts of rights, including human rights.

Methods of teaching / learning

Charaka has stated that medical wisdom is acquired by three methods (*upayani*):

1. Study ***(adhyayana)***, earnest and continuous
2. Teaching (***adhyapana***) : imparting lessons concerning life in general medical profession, medical ethics and science of medicine.
3. Academic discussions (***tatvidya – sambhasa***) with colleagues and fellow students.

Active learning is given great importance. Specific mention is made of medical ethics among the broad divisions to be taught. What are the methods to be employed today?

- Small group, problem-based learning
- Class-room teaching, especially of the larger concepts
- Seminars; debates on specific ethical issues
- Bed side clinics. Role model
- Case studies; written vignettes
- Doctor's stories; patient's stories
- Guest lectures

- Care of the terminally ill
- Death and dying
- Euthanasia; the living will
- Suicide.

4. **Special concerns**

- Human and animal research
- Organ transplantation
- HIV/AIDS; emerging / re-emerging diseases
- Rational use of drugs; ethical promotion of drugs
- Medical ethics and law
- Alternative systems of medicine.

General Medical Council, U.K.

The General Medical Council, UK, which regulates medical education, has worked out a core curriculum for medical ethics and law. This consists of

1. **Informed consent and refusal of treatment**
   - Respect for autonomy
   - Adequate information
   - Treatment without consent
   - Competence, battery, negligence

2. **Truthfulness, trust and good communication**
   - Building trust
   - Honesty; Values in clinical practice
   - Communication skills.

3. **Confidentiality**
   - Privacy
   - Compulsory/discretionary disclosure
   - Public vs. private interest

4. **Medical research**
   - Regulation of medical research
     - patients, volunteers, animals.

5. **Human reproduction**
   - Embryo; foetus
   - Assisted conception
   - Abortion
   - Prenatal screening

6. **Genetics**
   - Treating the abnormal vs. treating the normal
   - Genetic therapy and research

4. Where to Teach?

Most of the teaching will be in class rooms and conference halls to begin with but must gradually move to all outpatient teaching; inpatient bedside teaching and community based teaching (during community / rural / urban postings.)

5. Evaluation

a. All major subjects should have at least one short answer question on Medical Ethics appropriate for the subject introduced in the University question paper, and a few questions may be asked during the viva voce examination eg., basic principle in informed consent, confidentiality, etc.

b. Some felt that Evaluation may be formative indicating behaviour changes. This would include periodic assessments of knowledge and skill (example communicating skills), prize examinations, and honours - (university / college).

6. Recommendations to RGUHS

a. There is need to have learning resources such as reference books and case studies, AV aids, journals and newsletters to support Medical Ethics teaching in the colleges. RGUHS could do this through identification and dissemination of such resources.

The University could also gradually facilitate the preparation of work books or manuals or other teaching aids to facilitate the course.

b. There is need to support / facilitate sensitization workshops at regional / college levels where resource persons identified by the University can sensitize / orient / train teachers to support the training programmes.

c. There is need to constantly monitor the evolving experimentation in Medical Ethics teaching in different colleges and encourage greater interaction between colleges to learn from each others experiences. Exchange of resource persons could be facilitated.

d. Since this is a special and significant contribution to Medical Education in the country, the RGUHS should document the evolving process to evolve a more detailed curriculum outline and guidelines and work books that can be used not only in the state but elsewhere as well.

e. The starting of a correspondence course may be explored to prepare large numbers of teachers to develop an interest and skill in the teaching of ethics.

During these phases the course content mentioned in 3.3 to 3.10 may be taken up (See Appendix **C-5**).

Teaching methods may include lecture - discussions, case studies, role plays, debates, seminars and quiz. In the last four terms clinical case presentations can be included in which ethical issues in clinical decision making and patient care could be discussed (See Appendix **C-3**)

Inter college competitions, essays and debates could be encouraged to include current ethical dilemmas and issues.

Recommended distribution of Teaching hours in different phases of MBBS Course

Total Teaching Hours : 40

Phase I : Preclinical Period - 6 hours
2 hours each by Anatomy, Physiology, Biochemistry during the I year.

Phase II : Paraclinical Period - 6 hours
2 hours each from Pharmacology, Pathology and Microbiology.

Phase III: Community Medicine - 4 hours
2 hours each from Ophthalmology and ENT = 4 hours.
2 hours each in two terms from Medicine, Surgery, and OBG=12 hours
8 hours from other clinical departments.

N.B.: The teaching of Medical Jurisprudence by the department of Forensic Medicine will continue as before.

e) Internship

Ethical issues should be discussed during the grand rounds in each department.

Special Ethical case conferences can be introduced at least once a month during the internship

All interns must be encouraged to participate in at least one such special case conference during the period of internship.

B. Long term plan

As more of the faculty become involved in 'Medical Ethics' teaching, the issues of Medical Ethics should be discussed routinely as part of all bedside teaching.

e. Non core team medical teachers are to be included in teaching sessions from time to time to enable exposure and the development of interest in teaching Medical Ethics.

f. The core team may need a few more 'sensitization' and 'methodology' training before initiating the course. The team of St. John's Medical College and other resource persons identified by the University should plan and offer short courses to support this 'teacher training'. Alternatively some could join the distance learning course offered by National Law School of India University, Bangalore.

g. While the core team will share the main responsibility of teaching they should from time to time invite guest speakers and other resource persons from other faculties, Professions and disciplines and from 'Civic Society' to make their courses more interesting and stimulating .

B. Long term plan

h. All teachers should accept the responsibility of teaching and practising Medical Ethics in the collage and hospital. Medical Ethics should be component of all teaching in the Medical College.

3. When and How to Teach?

A. Short term plan

a. The course will be throughout the whole MBBS Course - starting from the pre-clinical phase till the end of internship.

b. For the present, 40 hours have been recommended during the 4 1/2 year period. All departments / disciplines will allot 2-4 hours each for medical ethics teaching for this integrated course. The details in the three phases follow.

c. Preclinical (1st & II term) (6 - 10 hours)

Following aspects of course content may be taught:

During this phase the Introduction to Medical Ethics (3.1 of the revised ordinance) and; Definition of Medical Ethics (3.2). Value orientation classes as is done in St. John's Medical College may also be included (See Appendix **C-4**).

Teaching methods may be lecture discussions and discussions with case studies (See Appendix **C-3**)

d. Para clinical and Clinical Phase II and III

No. of teaching hours - Para Clinical (10) Clinical (20)

A4: RECOMMENDATIONS AND ACTION PLAN

The following ecommendations were made by the participants during the Workshop: Medical Ethics in Medical Education organised by Rajiv Gandhi University of health Sciences, Bangalore (30 March / 1st April, 1999)

> ***[These workshop recommendations must be read in conjunction with and complements those guidelines. The Ordinance of the Rajiv Gandhi University of Health Sciences - 1997 which governs MBBS degree programme includes Section V - on Teaching of Medical Ethics in MBBS.]***

The Action Plan prepared for implementation of the curriculum in the medical colleges also formed part of the recommendations. The plan recommended short term and long term actions.

1. **The teaching of Ethics curriculum is the responsibility of all the faculty of the Medical College and not just those of one department or the other. The Ethics course will therefore be multi disciplinary, integrated and extend throughout the MBBS course and including the period of internship.**

2. **Who is to teach Medical Ethics?**

   A. Short Term Plan

   a. The Principals will meet all HOD's and faculty of their colleges and share the key recommendations of the workshop.

   b. They will select 4-5 members of the faculty who are motivated and interested to teach Medical Ethics. Volunteers must be encouraged. This team will form the core team for Medical Ethics. The team must include Clinicians. One member must be designated as Coordinator. This could be a rotating responsibility. The core team is responsible for initiating and organising activities regarding Medical Ethics.

   c. The institution should have a structure which would consider and help in the ethical issues involving medical education, patient care and research. One suggestion is that the institution should also appoint a College Ethics Committee (CEC) and a Hospital Ethics Committee (HEC) which could include the above team members and others. These committees will be responsible for 'ethical issues' in medical education, patient care and research apart from supporting the planning and execution of the Medical Ethics teaching programme. The core team will co-ordinate with the activities of the Medical Education Cell and the Postgraduate training and research committee. (See Appendix 8 & 9).

   d. The core team will organise meetings and workshops to sensitise all the teachers including HOD's to the needs and challenges of Medical Ethics in undergraduate education.

decisions in their day to day medical care and health care work. (See Section B-5 for details).

21. After the participants had an opportunity to get more details and clarifications from the St. John's team, they broke into groups for the final and most important task for the workshop i.e., to evolve an Action plan for implementing RGUHS curriculum on Ethics.

    The groups were made in such a way as to allow for regional level continued interaction among them after the workshop:

Group I	BLDEA Bijapur; Al Ameen, Bijapur; MRMC, Gulbarga; VIMS, Bellary; JNMC, Belgaum.
Group II	AIMS, Bellur; Government Medical College, Mysore; JSS-Mysore, St. John's Medical College, Bangalore.
Group III	BMC; KIMS, Bangalore; AMC, Bangalore, DUHC, Kolar; Siddartha, Tumkur.

    Each group was asked to respond to four questions as a task to arrive at an Action Plan. These were i) Who is to do the teaching; ii) When and How and where to teach; iii) How to evaluate; iv) Any other issues in teaching of Medical Ethics.

    Each group had resource persons to help in the discussion. Members of the St. John's Medical College team were requested to be additional resource persons in each of the three groups.

    After an interactive, participatory and enthusiastic group discussion, three action plans emerged which have been integrated in the next section. These were presented at the final plenary session at which a small committee was formed to integrate the suggestions and take this agenda forward.

22. The participants were given certificates of participation and the workshop concluded having generated a lot of enthusiasm and commitment in the group, to make the new experiment of RGUHS - of introducing Medical Ethics as a curriculum subject in Medical Education in Karnataka, a success.

Day 2

19. The key theme of the second day was Teaching/learning ethics and after a very concise but comprehensive report of the first day by Dr. V.L. Pattankar and Dr. T.K. Nagabhushan, the session started by a keynote address by Dr. C. M. Francis, Consultant – CHC, Bangalore on **Teaching/Learning Medical Ethics in Medical Education** (See Section B3)

    His comprehensive overview included Medical Ethics and national goals; some examples of Ethics courses form other parts of the world – both graduate and postgraduate; objectives of teaching ethics; curricular design and content; methods of teaching and learning ethics, resources and who will teach and some issues in assessment as well as some obstacles to teaching ethics which should be overcome.

20. Following the keynote address, the St. John's Medical College Ethics training team then made a comprehensive presentation of all facets of Ethics teaching at St. John's. The teaching of Ethics was started in 1965 and over the years the contents and teaching style have been modified based on feed back and reflection.

    Dr. Prem Pais started by answering six general questions that would be faced by all medical college teachers who embark on an Ethics course in the curriculum. These were i) Should and can Medical Ethics be taught?; ii) What are the attainable objectives of Medical Ethics teaching?; iii) Who should teach Medical Ethics?; iv) When and to whom should Medical Ethics be taught?; v) How should Medical Ethics be taught?; vi) Evaluation – can it be done for Medical Ethics course? He then answered these in the context of the St. John's experience (See Section B5).

    Dr. G.D. Ravindran then outlined the stresses and strains faced by a new medical college entrant at the beginning of the course and how a few sessions on value orientation would help them to understand ethical choices and dilemmas. He then went on to explain the curriculum on Value Orientation which was introduced at pre-clinical level at St. John's Medical College (See Appendix C-4). He also outlined the the curriculum for UGs and the methods used including the nature of the assessment. He highlighted some of the constraints faced by the ethics' course teachers which included lack of relevant reading material and studies in relation to the Indian context, and lack or skewed 'role models' in the institution.

    Dr. Sanjiv Lewin enthusiastically presented the interns programme highlighting the issues discussed and methods utilized. He stressed from the St. John's experience, the need to involve all the departments in the programme. With numerous case studies he brought out the dilemmas in ethical teaching as well. The main challenge was to make students sensitive and aware of the issues; think for themselves; decide and refer to peer support and guidance when required. (See Section B5 for further details).

    Finally, Fr. Kalam, the Professor of Medical Ethics at St. John's summarised the need for making ethics central to medical care and the need to make the 'ethics curriculum' produce doctors who were equipped to make their own ethical

d) Justice and Equity

i) Loss of job opportunity due to genetic disposition; ii) Loss of health insurance; iii) Allocation for services and access; iv) conflicts of interest.

(See Appendix C 7– for further details).

16. Following the three presentations, the participants deliberated in five small theme specific groups. The group discussions were interactive and interesting and all the participants actively participated. Each group was given a set of questions to stimulate the group discussion (See Appendix **C-6**) The main purpose was to give the participants an experience of identifying the ethical issues and dilemmas in different areas of current medical practice or health care. (see Appendix **C-7**)

17. In the plenary session, Dr. Sambashiva Rao presented the group reflections on Alternative Systems of Medicine, followed by some comments by Dr. Jayaprakash, Member – Central Council of Indian Medicine who was the resource person for the group.

Dr. Sanjiv Lewin reported the ethical dilemmas of Assisted Reproductive Technology and Dr. Gomathi provided additional comments as the resource person for the group.

Then, Dr. O.P. Bhargava presented a report on Genetics and Medical Ethics followed by some comments and further clarifications by Dr. Sayee Rajangam – Prof. of Anatomy of St. John's Medical College.

Dr. Chandrashekar presented a report on the ethical dilemmas in Organ transplantation followed by comments and further clarifications by Dr. H.S. Ballal who was resource person for that group. (See Appendix C-7)

Finally, Dr. Medha Rao highlighted the key issues and dilemmas on Patients Rights. Dr. Francis added further comments. (See Appendix C-7)

18. The group reports were followed by intense, discussion in which participants raised several important questions and resource persons including Dr. Kantha, Dr. C.M. Francis, Dr. D.K. Srinivas and Dr. Ravi Narayan provided helpful clarifications and observations.

While the keynote addresses and the input sessions had provided lot of stimulus for the participants, the enthusiastic participation in the group discussions was proof enough that the challenges of understanding the ethical issues and dilemmas was beginning to receive the serious consideration it deserved. A key issue that came up again and again during the plenary was the need for greater effort to 'ethicalise' the teaching, patient care and community care and examination environment in the medical colleges to support the teaching of ethics as a curriculum subject. This was a significant concern.

collaboration as well as donor driven research. (Please see ICMR - 1997-98 guidelines for further details).

12. Session five was designed as an interactive group discussion session. The participants were divided into five groups and each group was guided by a resource person. The topics were: a) Alternative Systems of Medicine; b) Assisted Reproductive Technology; c) Genetics and Medical Ethics; d) Organ transplantation and e) Patients Rights. Since, some of these were of great significance in the context of recently emerging events and concerns, three resource persons made short presentations to all the participants before they met in small groups for discussion.

13. Dr. H.S. Ballal, Director, Manipal Institute of Nephrology and Urology, gave a short overview of the ethical issues in organ transplantation by presenting 2 recent case studies. He emphasised the ethical principles of transplantation including i) no harm to donor; ii) informed consent; iii) significant benefit to recipient. He outlined the unethical practices which included utilizing a) donor who is unfit; impaired decision making capacity; b) Coercion/blackmail; c) Commercialization/middlemen. He went on to highlight the issues in living transplant. These included i) Altruistic stranger; ii) Grey basket (rewarded gifting); iii) Rampant commercialization; iv) Criminal. He listed out four key issues in cadaver transplant: i) brain death; ii) directed donation; iii) incentive for donation; iv) who gets the organs? decision. Finally, he touched upon four other issues in the context of transplant which included a) donations from minors/mentally retarded; b) donations from prisoners; c) donations from embryo/fetus; d) xenografts.

14. Dr. Gomathi Narayan, Professor of Obstetrics and Gynaecology, Kempegowda Institute of Medical Sciences, Bangalore, then gave a short summary of a survey she undertook of 50 internees about the knowledge and attitude to ART and the questions that they raised which had important ethical dimensions. (see Appendix **C**-7)

15. Dr. Sayee Rajangam, Professor of Anatomy, St. John's Medical College, shared 16 ethical issues in **genetic counselling** outlined under the four major principles of ethics. These were illustrated with examples.

    a) **Respect for autonomy**:
    i) Genetic testing with difficult follow up choices; ii) Testing of children; iii) Pregnancy termination for mild conditions; iv) Sex selection; v) PND to select for an affected individual.

    b) **Beneficence and non-maleficence**;
    i) Experimental therapy (Gene therapy); ii) PND and its appropriateness.

    c) **Privacy and confidentiality**
    i) Paternity; ii) Duty versus confidentiality; iii) Wrongful life; iv) Wrongful births.

she highlighted that the RGUHS Ethics curriculum already included some of these issues and needed to be discussed with medical students during the course.

11. Dr. Vasantha Muthuswamy, Deputy Director General of Indian Council of Medical Research, New Delhi gave a comprehensive overview of the **Ethical issues and challenges in medical research** and the emerging guidelines for research on animals, human subjects, and bio ethics. She traced the evolution of ethics and ethical principles over the centuries and then highlighted all the codes of ethics for research from Nuremberg Code (1948) till the evolving ICMR's ethical guidelines on Biomedical research involving human subjects (1997). See box

EVOLUTION OF MODERN BIO ETHICS (BIO MEDICAL ETHICS)

- ***Nuremberg Code (1948)***
- ***Universal Declaration of Human Rights***
- ***Helsinki Declaration (1964)***
- ***National Commission for the Protection of Human subjects of Biomedical and Behavioural Research, USA (1979)***
- ***Policy Statement on Ethical issues in Biomedical Research on Human Subjects, ICMR, India 1980)***
- ***Proposed International Guidelines on Biomedical Research, WHO/CIOMS (1982)***
- ***Ethical guidelines for Epidemiological Research - WHO (1991)***
- ***Ethical guidelines on Biomedical Research - Human Genetics (1990)***
    - ***Human Tissues (1993)***
    - ***Xenotransplantation (1995)***
- ***Ethical guidelines on Biomedical Research involving Human Subjects, ICMR, India (1997)***

She outlined the general principles included by ICMR in its recently evolving guidelines for biomedical Research on Human Subjects in India which included (i) Essentiality (ii) Voluntariness, informed consent, community agreement (iii) non-exploitation (iv) privacy and confidentiality (vi) professional competence (vii) Accountability and transparency (viii) Public interest and distributive justice (ix) Institutional arrangements (x) Public domain (xi) Totality of responsibility (xii) Compliance. The ICMR evolving guidelines also include specific principles and guidelines for a) Human Genetics b) Organ transplantation including fetal tissue transplantation c) Clinical evaluation of Drugs / Diagnostics / Vaccines / Herbal remedies d) Epidemiological Research e) Assisted Reproductive Technologies.

She then outlined some of the issues in animal experimentation and research and some of the problems of collaborative research especially international

ii. The Declaration of Geneva (1948)
iii. The Oath of Professional Fidelity (later amended in 1968 and 1983)
iv. The Duties of the Physician in general, to the sick; and to others (1949)
v. The code of Medical Ethics of the Indian Medical Council Act (1956).

He described the challenge of new bio technology and medical procedures and therapeutics like Assisted Reproductive technologies; Organ transplantation; and human genome analysis and gene therapy.

Finally, he described the widening vision and challenge of ethics beyond the confines of the doctor-patient relationship including issues relating to health policy; health economics; health as a human right; distributive justice in health care and allocation of resources; the Health for All goal, and bioethical issues in Population Health, Equity and Human Rights.(See Section **B-4**).

8. In Session 4 ethical issues related to patient care, public health and medical research were highlighted by resource persons. The session was chaired by Dr. D.K. Srinivas.

9. Dr. Om Prakash, Head of Department of Medicine from St. Martha's Hospital, Bangalore, spoke on ***Ethical issues related to Patient Care*** with suitable examples from day to day clinical practice. His lucid presentation covered a large number of issues related to ethical medical care especially the clinical approach; the art of communication; the role of caring, comforting and education; the diagnostic process and the degree of investigation; the cost factor; the role of clinical acumen; judicious use of procedures; cost of care and need for care; issues in hospitalisation and those involved in advising expensive therapies; life support systems; admission decisions; dialogue with patients and relatives; moral dilemmas and their magnitude; and newer problems due to evolving tests, biotechnology and therapeutic modalities. He particularly stressed the urgent need to help develop culture sensitive and effective communication skills in medical students and interns to enhance the practice of ethical care for their patents.

10. Dr. Thelma Narayan, Coordinator of the Community Health Cell, an Epidemiologist and Public Health Policy Consultant then explored the key **Ethical issues related to Public Health**. She highlighted the individual versus community dilemma; the right to health; the challenge of distributive justice and equity; the need for priority setting; the dilemma of 'health for some' versus health for all; the commercialisation of health care; the corruption and political interference; the continuing discrimination based on gender, caste or communal factors and the violence of the state.

    She then highlighted some indicators of fairness in ethical health care such as universal access; minimising non financial barriers; emphasis on primary care and prevention; public accountability and democratic decentralisation. She identified some disturbing trends in the country like commercialisation of medical education; privatization and glorification of hi-tech diagnostics, doctor-drug-producer axis and others which were making health care more unethical. Finally

Ethical issues in Medical Research

35. Can a study be done even though it has already been proved before? Can a pharmaceutical company sponsor a study and decide whether to publish or not? What is the duty of the doctor after completion of the study especially if the results are not in favour of the company?

36. Can children be included in any study? From who shall consent be asked? Can a person walk away from a study before its completion? Can you pay the study subjects? Can you ask medical students in your institute to participate in a study?

37. Can a study be done in a third world country when it has been disallowed in the west?

38. Can animals be used in studies? Can animals be not used in studies especially with respect to drug trials? Which animals would you object to in a study – dogs, cats, rabbits, ants, cockroaches? Why are there different responses depending upon the type of animal?

39. Can prisoners be used for experiments?

40. Who should implement the MCI's code of conduct?

24. Do medical students have a right to examine and see patients in a medical college hospital? In the general ward? In the private ward? If different, is this discrimination?

25. Does a doctor have the right to screen a patient for HIV before treatment? Does the patient have a right to know the doctor's HIV status?

26. Can a homosexual family or a single parent have a right to ART?

27. Can a donor sperm, ovum or zygote be stored? Destroyed? Who owns them if the donor dies?

28. Should the identity of the donor and recipient of a cadaveric donation be kept secret? Should the donors family decide who gets the donation? Should a non resident of a place be given the donation? Who owns a cadaver if unclaimed? Can we afford the concept of brain death? Who will pay for the life support once brain death is declared and before the actual transplant is carried out?

29. Is it necessary to have a chaperon during the examination of a lady patient? In Ophthalmology?

30. An interesting patient is admitted to the ward which is a potential publication. Can we take a photograph of the patient and the lesion and send it for publication? Do I need permission? Can I publish the problem in a newspaper? Can I publish about availability of my specialized services in the newspaper? Can I be photographed and interviewed in a newspaper as a good doctor? Can I have my name, address and telephone number in the newspaper? In the yellow pages?

31. Can a patient demand a second opinion and then return to the first doctor for treatment? Can a patient go shopping for the best deal? Can a patient ask for a particular surgeon to operate on him or her? Can the patient decide his or her own treatment plan?

32. Can sex determination be done in a prenatal clinic? Can any other prenatal screening be done with the possibility to terminate life? Can universal screening be done without parental consent? Whose consent –father or mother or both?

33. Can genetic engineering be used to correct defects? Can it be used to correct cosmetic anomalies? Can it be used to produce the perfect person? Who decides what is right? What right has the person deciding have that the condition or anomaly or feature is bad or good hence decide the termination of life? What right has anyone to prevent a family from preventing the birth of a child who is defective and who will suffer or die early in life? Can the doctor distance himself from the decision making and leave it to the parents? Is it not the same as describing all the methods to murder and leaving the decision and responsibility to the person? Is it separating science from ethics?

34. Can abortions be carried out to obtain fetal tissue for transplants? Can animal tissue be used for similar purposes?

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MP-2.

ETHICS AND HEALTH CARE REFORMS
A GLOBAL VIEW

Norman Daniels

Chapter in forthcoming CIOMS publication entitled
Ethics, Equity and Health for All (in press)

ETHICS AND HEALTH CARE REFORMS:
A GLOBAL VIEW

Norman Daniels*

My comments today fall into three parts, a brief sketch of my views about justice and health care and their implications for the design and reform of health care systems, some remarks about the ethical implications of market reforms in the United States and Europe, and some preliminary thoughts about the bearing of all of this on the health for all strategy in developing countries. I emphasize the "preliminary" nature of these last remarks, since I must learn from all of you enough about the problems in developing countries to say anything truly useful about them. I conclude with a suggestion that a project be undertaken to adapt a method of assessing "benchmarks of fairness for health care reform" that I developed (with Don Light and Ron Caplan[1]) for use in evaluating reforms in countries at various stages of development.

I. Justice and the Design and Reform of Health Care Systems

Nearly 20 years ago, I began to think about what contemporary work on the general theory of justice implied about the distribution of health care. Could that work provide foundations for a right to health care and clarify what it meant?

Using a narrower notion of health than the WHO definition, namely, species-typical normal functioning ("normal functioning" for short), I argued that the central contribution of health care in any of its forms, whether public health, preventive or acute or chronic care, physical or mental, was to keep people functioning as close to normally as possible within reasonable resource constraints. Disease and disability, viewed as departures from normal functioning, restrict the range of opportunities open to individuals, preventing them from participating as they otherwise might in the economic, social and political life of their societies. Health care, by promoting normal functioning, thus makes an important, if limited, contribution to assuring equality of opportunity, and this gives an explanation of its special, though not unique, moral importance (see Daniels 1985[2], 1988[3]).

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Although this focus on equality of opportunity might seem to emphasize the importance of health care to the individual, in contrast to European appeals to the more communitarian concept of solidarity, there really is deep point of convergence. Both ways of conceiving the problem agree that we must share the burdens of keeping people as close as we can to fully functioning participants in the political, social, and economic life of society. Herein lies the sense in which health care is a social good, for promoting the health of each contributes to the social well-being of all.

This equal opportunity account of the justice and health care has important implications for the design of health care systems, including for access, for types of services, and for financing. For example, it provides foundations for universal coverage, since ability to pay should not be a precondition for securing protection of equal opportunity. It also provides foundations for needs-based allocation of resources, since the relative impact on opportunity becomes a way of assessing the relative importance of meeting particular health care needs. Since protecting equality of opportunity is a social obligation, the burdens of providing that protection should be distributed according to ability to pay. The principled account of justice and health care is in theory compatible with both public and mixed private/public financing and delivery systems. It is also compatible with some forms of "tiering" -- being more concerned about the structure of inequality that emerges than the mere fact that some inequality is present. Thus, a system that allowed a small best-off sector of society a more deluxe health care tier at the top, while treating the majority of society adequately, is open to fewer ethical objections than a system that allows better off groups to leave the worst-off groups behind with just bare minimum.

The equal opportunity account can give much more specific guidance in thinking about the fairness of health care reform. Don Light, Ron Caplan, and I, and drawing on work I had done with Dan Brock while we were on the Ethics Working Group of the Clinton Health Care Task Force, developed the implications of this account into a matrix of ten "benchmarks of fairness", involving some 30 criteria, for assessing the fairness health reform in the United States (see Daniels, Light, and Caplan 1996[1]; see Appendix I below). For example, Benchmark 1 evaluated financial barriers to access to services --- how much of the large insurance gap in the United States was reduced by the reform -- and it also asked if the coverage was "portable" from job to job. Benchmark 2 evaluated non-financial barriers to access. Benchmark 3 evaluated the comprehensive of benefits and the kinds of tiering that the reform allowed. Other benchmarks of fairness considered equity in financing (community rating and the progressivity of financing), clinical efficacy (an emphasis on primary care and on outcomes based medicine), administrative efficiency, public accountability, and the degree of choice available in the system. We used the matrix to make a comparative assessment of the fairness of several major health care reform proposals before the 103rd Congress -- none of which were adopted -- and to assess the market driven changes that accelerated in the aftermath of the collapse of political reform.

I mention this effort not because the ten benchmarks and thirty criteria provide the best framework as they stand for thinking about ongoing health care reform around the world -- they were not constructed with the special problems of very poor, developing societies in mind -- but because they provide a model for how to make equity and fairness considerations play a role in the evaluation of health care reforms. I believe these benchmarks can be modified, for example, by expanding those criteria that concern public health and primary care, to reflect the crucial importance of these components in developing countries and to emphasize their sensitivity to the introduction of market reforms.

II. Evaluating the Ethical Impact of Health Care Market Reforms

A. Market reforms in the U.S.: With the failure in 1994 of a political effort at health care reform in the US, large employers have undertaken their own measures to control rapidly rising health care costs. As large scale purchasers, they have fuelled competition -- largely on price -- among competing health insurance plans, organized into quite varied forms of managed care arrangements. It is important to note that this competition involves not only *financing* but *production*.

The precise effects of this market driven change (I hesitate to call it "reform") are not well documented, but there is good evidence for these trends:

1) The numbers of uninsured have increased even though health care costs to employers -- at least large employers -- have plateaued. This

increase is true despite an excellent economy with relatively low unemployment. Fairness is diminishing as measured by Benchmark 1, for universal coverage. One modest counterforce is the new Federal legislation that goes into effect in July and which limits the ways in which insurers competing to secure healthier patient pools may exclude patients with prior medical conditions. These steps go only a fraction of the way toward the protection that would have been provided by two of the comprehensive national reform proposals (Wellstone's, modelled on the Canadian system, and the Clinton plan).

2) The rate at which Americans have been pushed (or pulled) into managed care arrangements has increased. In the private insurance sector, a majority of Americans are not covered by such plans. In the public sector, the majority of Medicaid patients now have such coverage, and an increasing proportion of Medicare patients do as well. For many people this has meant a disruption of long-standing relationships with particular physicians. For others, especially those with chronic health problems, there is reduced access to specialty care and to choice among those providing such care. Because of Federal laws exempting "self insuring" corporations from state regulations regarding insurance, there is also less accountability to the public for the quality and scope of benefits enjoyed by an increasing proportion of workers. The loss of choice and of accountability mean these trends increase unfairness as measured by other benchmarks we use (Benchmarks 8 and 10). James Sabin and I (Daniels and Sabin 1997[4]) have been examining ways in which accountability for decisions about coverage of new treatments might be increased; the lessons generalize to include broader questions about limit-setting in private organizations. A revision of the benchmarks to cover privatization in developing countries should emphasize the importance of publicity and accountable in the procedures for limit-setting decisions.

3) The dominant form of competition that has emerged has been on price (premiums) and not on quality. Indeed, employers have found they have limited technologies available for measuring the relative quality or efficiency of competing health plans. There has been a push to develop some such measures (e.g. HEDIS), but in their absence, the piece of market theory that says informed consumers (here employers) can use competition to improve quality and not just price remains untested. Instead, we have considerable anecdotal evidence of patient dissatisfaction with quality, and what survey information we have suggests the dissatisfaction increases the sicker the patients are.

This suggests we should worry about the degree to which these trends decrease fairness on the criteria concerning the comprehensiveness and quality of services covered (Benchmark 3).

4) Though costs to large employers have stopped rising rapidly, and in some cases may actually have decreased, there is also a growing concern about cost-shifting. In the US, services to uninsured patients were often cross-subsidized by increasing the premiums of insured payers. As room for this form of cost-shifting is eliminated in the system, there is greater cost-shifting to public budgets that support unreimbursed hospital care in public hospitals. There is also considerable shifting of some costs to out-of-pocket payments by patients, including private contributions to cover reduced coverage for dependents provided by many employers. Thus unfairness increases on some of the criteria governing fairness in the sharing of burdens for financing health care (see Benchmarks 4 and 5).

5) Despite the slowing of the growth of premium costs to large employers, there is evidence that the proportion of health care costs going to profits and administrative costs -- rather than health services -- is increasing, especially with the rapid growth of a for-profit health care sector. These costs run well over 25% in some cases. To show that these costs are justifiable, one would have to show that the quality and scope of coverage was not reduced, and was even improved, while permitting scarce public and private health dollars to be diverted in these ways. No one has any evidence to show that (see Benchmarks 6 and 7).

B. **Market Reforms in Europe**: In the brief time I have today, I cannot review in any detail the lessons from European "planned market" health reforms. Fortunately, there are some excellent reviews of these reforms (Cassel 1995[5], Saltman 1995[6]) on which I draw here:

1) With the exception of the Netherlands, among the European OECD countries, there has been little interest in introducing competition on the finance side. The Dutch experience suggests considerable threats to solidarity, and that is in a country with a strong legacy of concern about solidarity, but this is a lesson that could have been learned from the U.S. context; a technical obstacle that faced the Clinton reform was the lack of a good technology for risk-adjustment that would remove the incentive of competing insurers to segregate risk pools. Using the benchmarks of fairness we used to evaluate the Clinton and other proposals, we would have to mark

down the score of the Dutch experiment just as we did for the Clinton proposal, since there were technical obstacles to assuring fairness even though there is awareness of the importance of avoiding risk exclusions (the issues arise with reference to Benchmark 4).

2) There is much more experience with planned market reforms that involve allocative and production aspects of the health care system. New contract relationships may replace command-and-control public bureaucracies; patient choice can be made to play a new role on the demand side that affects budgetary decisions; physician reimbursement schemes may be made to include competitive elements through new capitation or other incentive mechanisms. One lesson learned from some of these measures is that transaction costs can be much higher than expected (cf. Benchmark 7). Increased efficiency does not always accompany mimicry of market methods. A second lesson is that the goals of some of these steps alter rather than really reduce the importance of the role played by the state. They call for increased state monitoring and regulatory roles if there is to be any assurance that social goals in health care are not being undermined. A detailed analysis of these reforms, using modified versions of our benchmarks for fairness, would highlight their impact on equity issues. I cannot undertake that analysis here, but a research project to adapt the benchmarks for international use would have to examine current experience carefully.

III. Implications for Developing Countries

A. Two contradictions: I advance these comments with considerable trepidation because of my limited knowledge of developing countries. I trust I will be corrected where I say foolish things and unhelpful things.

There seems to be two key motivations for emphasizing the importance of a private sector and market mechanisms as a component of health care reform in developing countries. Each, I believe, leads us to a contradiction. Let me explain.

First, the grave scarcity of public material resources in many of the poorer developing countries means that it is tempting, even necessary, to look to encouraging development in the private sector. By taking pressure off public resources, it may be possible to target them better to meet the needs of the poorest sectors. The contradiction here -- revealed by the U.S. and

European experience -- is that some forms of growth in the private sector will undermine the public sector rather than strengthen its ability to meet the needs of the poorest and most vulnerable groups. For example, low public salaries paid to primary care personnel in the public sector, combined with new opportunities to work part-time in the private sector, can lead to reduced availability of public sector personnel and increased costs. It is also important to keep in mind the different problems for which market reforms are introduced in wealthy, developed countries and poorer, developing ones. Oversupply and overutilization of some resources in developed countries may be corrected by some market mechanisms (if transaction costs do not prove prohibitive), but that is a very different task from what is envisioned in countries with scarcity of resources.

Second, entrenched, bloated bureaucracies, or ineffective and weak government structures, complicated in some cases by widespread corruption, act as significant obstacles to achieving primary health care and other health-for-all objectives. The antidote that is promoted is the promise of much greater efficiency and creative energy in private sector health markets. The contradiction here -- again illuminated by the European experience -- is that planned market reforms do not reduce or eliminate the need for a strong state role in planning, monitoring, and regulation. If the problem is an ineffective and weak public sector, then encouraging private market growth may make it difficult both in the short and long run to preserve fairness in the health care system.

The point of highlighting these as contradictions is not to imply that no attempt to increase private sector resources or market reforms is justified. We may well be driven to such steps out of necessity. Rather, the point is that we must examine the implications of all such proposals for their impact on the fairness of the system as a whole, and we should do so in a way that is not blinded by market ideology.

IV. Extending the Benchmarks of Fairness

The CIOMS/WHO concern about equity in health care reform prompts me to propose a research project aimed at modifying and extending the benchmarks of fairness methodology for use in monitoring ongoing health care reforms around the world. Ideally, such a project would involve a close look at a range of particular countries at different levels of development that have been undergoing diverse sorts of reform (e.g., Pakistan, Thailand, Finland,Ghana). In that way, criteria can be fine-tuned to reflect crucial features in that broad range of contexts. The benchmarks developed for evaluating U.S. reforms are limited because the types of reforms there envisioned had little to do with modification of public health, for example.

A brief glance at the case of Thailand (Sanguan Nitayarumphong and Supasit Pannarunothai 1996[7]) suggests that the benchmarks could be readily modified to address the concerns that have arisen there about equitable financing, universal coverage, equalization of benefits, equitable allocation, geographical barriers, quality, clinical and financial efficiency. All of these are already incorporated in the benchmarks, but revision of the criteria, including additions to them, are needed to make them capture specific features of the Thai situation. Once criteria were refined, an appropriate scale could be adopted, and some inter-country applications of the matrix could be attempted. The result might be a way to show that some types of reforms undertaken in particular contexts tend to have a specific pattern of effects -- across a wide array of countries and conditions -- on equity or fairness. We might then be in a better position to make evidence-based arguments about the fairness of certain reforms. It might then become quite clear how different market and public sector reforms contribute to a multi-dimensional analysis of equity or fairness considerations. Using such a tool may make it possible to avoid the simplistic "pro" or "con" debate that has surrounded at least the earlier stages of proposals regarding market-oriented health care reform.

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Appendix 1

Table 3-2. Benchmarks of Fairness for National Health Care Reform

Benchmark 1:	Universal access - Coverage and Participation
	Mandatory coverage and participation
	Prompt phase-in: Coverage/participation not held hostage to cost control
	Full portability and continuity of coverage
Benchmark 2:	Universal Access - Minimizing Nonfinancial Barriers
	Minimizing maldistributions of personnel, equipment, facilities
	Reform of health professional education
	Minimizing language, cultural, and class barriers
	Minimizing education and informational barriers
Benchmark 3:	Comprehensive and Uniform Benefits
	Comprehensiveness: All effective and needed services deemed affordable, by all effective and needed providers. No categorical exclusion of services, like mental health or long-term care
	Reduced tiering and uniform quality
	Benefits not dependent on savings
Benchmark 4:	Equitable Financing - Community-Rated Contributions
	True community-rated premiums
	Minimum discrimination via cash payments
Benchmark 5:	Equitable Financing - By Ability to Pay
	All direct and indirect payments and out-of-pocket expenses scaled to household budget and ability to pay
Benchmark 6:	Value for Money - Clinical Efficacy
	Emphasis on primary care
	Emphasis on public health and prevention
	Systematic assessment of outcomes
	Minimizing overutilization and underutilization
Benchmark 7:	Value for Money - Financial Efficiency
	Minimizing administrative overhead
	Tough contractual bargaining
	Minimize cost shifting
	Anti-fraud and abuse measures

Benchmark 8:	Public Accountability Explicit, public, and detailed procedures for evaluating services, with full, public reports Explicit democratic procedures for resource allocation Fair grievances procedures Adequate privacy protection
Benchmark 9:	Comparability A health care budget, so it can be compared to other programmes
Benchmark 10:	Degree of Consumer Choice Choice of primary-care provider Choice of specialists Choice of other health care providers Choice of procedure

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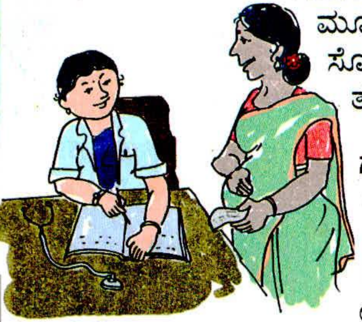
From: Daniels, N, Light D, & Caplan, R. *Benchmarks of Fairness for Health Care Reform*, p. 68, New York, Oxford University Press, 1996.

ಹೆಚ್‌ಐವಿ ಸೋಂಕಿತ ಗರ್ಭಿಣಿ ತಾಯಿಯಿಂದ ಸೋಂಕುಮುಕ್ತ ಮಗು ಪಡೆಯಬಹುದಾಗಿದೆ.

ಹೆಚ್‌ಐವಿ ಸೋಂಕು ಇರುವ ಮಹಿಳೆ ಗರ್ಭ ಧರಿಸಿದರೆ ಮಗುವಿಗೆ ಸೋಂಕು ತಗುಲುವ ಸಾಧ್ಯತೆ ಇದೆ. ಐಸಿಟಿಸಿ ಸೇವೆಯಿಂದ, ತಂದೆ-ತಾಯಿಯ ಮೂಲಕ ಮಗುವಿಗೆ ಸೋಂಕು ಹರಡುವುದನ್ನು ತಡೆಗಟ್ಟಬಹುದಾಗಿದೆ.



ಗರ್ಭಿಣಿ ಸ್ತ್ರೀಯರು ತಪ್ಪದೇ ಹೆಚ್‌ಐವಿ ಪರೀಕ್ಷೆ ಮಾಡಿಸಿಕೊಳ್ಳಬೇಕು. ಕಡ್ಡಾಯವಾಗಿ ಸರ್ಕಾರಿ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಹೆರಿಗೆ ಆಗಬೇಕು. ವೈದ್ಯರ ಸಲಹೆಯಂತೆ ಸೂಕ್ತ ಔಷಧೋಪಚಾರ ಪಡೆದು ಹುಟ್ಟುವ ಮಗುವನ್ನು ಹೆಚ್‌ಐವಿಯಿಂದ ರಕ್ಷಿಸಬಹುದಾಗಿದೆ.
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ಶ್ರೀ ಯು. ಟಿ. ಖಾದರ್
ಮಾನ್ಯ ಸಚಿವರು
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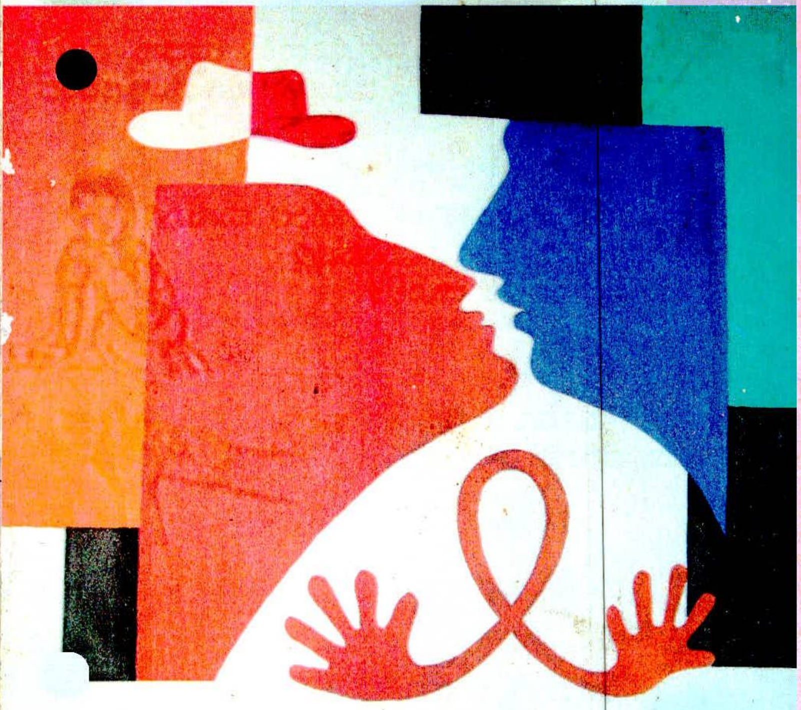

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Indian Post, 25/11/88 pg. 3

For Dr W.V. Ram
fr Anil Pilgaonkar.

ACASH secretary's dismissal stayed

By A Staff Reporter

BOMBAY, Nov 24

Secretary of the Association for Consumer Action on Safety and Health (ACASH) Dr Arun Bal, whose services as honorary surgeon at the Dhanvatri Hospital and Medical Research Centre were terminated without assigning reasons, has approached the labour court under the Unfair Labour Practices Act.

Presidency officer of the 9th labour court A D Deshpande has granted an ad-interim injunction and ordered the secretary of the Brahman Sahayak Sangh, which runs the hospital at Shivaji Park, to temporariiy withdraw the termination order, after hearing the doctor's advocate, Chander Uday Singh. Bal can thus look after his indoor and outdoor patients for the scheduled time.

The case is expected to come up for hearing again tomorrow.

In his complaint made in his capacity as an employee, Bal said he had been appointed as a honourable surgeon in September 1984 and had thus performed his duties continuously in the 50-bedded hospital which is run by a public charitable trust. Apart from Bal, there are 45 other doctors and surgeons employed as honorarians.

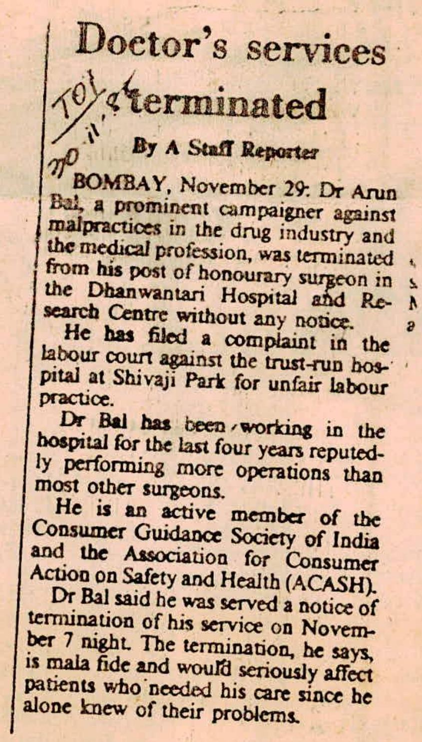
Bal has further stated that throughout his career, first as a lecturer in surgery at JJ Hospital and as assistant professor in surgery and later as a practicing surgeon, he has had an outstanding record. He also pointed out that his relations with his patients as well as his colleagues were extremely genial.

Apart from his career, Bal has enumerated his interests which include social and public interest causes, particularly on behalf of consumers affected by sub-standard drugs and medical malpractices. As founder-secretary of ACASH, he had been in the forefront of that organisation's activities like taking up the ban on sale of harmful drugs and filing of petitions in the Bombay High Court in this regard. "However, the complainant's aforesaid activities has not made him very popular with the establishment," the complaint says.

On November 7, the secretary of the trust came to his residence at 9.45 pm and handed over the letter terminating his services to his "utter shock and surprise", says the complaint. It adds that the secretary refused to state the reasons or comment on the late hour of delivery.

Bal pointed out that as surgeon he performed very critical and delicate operations upon his patients and a crucial aspect was post operative care. Any shortcoming would thus result in disastrous and life-threatening complications. Therefore, any last moment change in the doctor treating the patients can have bad consequences.

The complaint says that the termination was utterly *mala fide* and smacked of victimisation. His termination was in utter disregard of natural justice in as much as he was not given the barest opportunity of a hearing before the termination. As his record had been outstanding and there could be no valid reason for terminating his services in the surreptitious and hasty manner, which shows that it was effected for oblique and collateral purposes and as a measure of punishment for some imagined grievances.



Doctor's services terminated

TOI 30.11.84

By A Staff Reporter

BOMBAY, November 29: Dr Arun Bal, a prominent campaigner against malpractices in the drug industry and the medical profession, was terminated from his post of honourary surgeon in the Dhanwantari Hospital and Research Centre without any notice.

He has filed a complaint in the labour court against the trust-run hospital at Shivaji Park for unfair labour practice.

Dr Bal has been working in the hospital for the last four years reputedly performing more operations than most other surgeons.

He is an active member of the Consumer Guidance Society of India and the Association for Consumer Action on Safety and Health (ACASH).

Dr Bal said he was served a notice of termination of his service on November 7 night. The termination, he says, is mala fide and would seriously affect patients who needed his care since he alone knew of their problems.

Enclosure (1)

MP-2

DEAKIN UNIVERSITY ETHICS COMMITTEE

Application for Ethics Approval

GUIDELINES

1. The University Ethics Committee

Deakin University has two institutional ethics committees; the Animal Experimentation Ethics Committee which has its terms of reference composition and procedures determined by The Prevention of Cruelty to Animals Act 1986, and the Ethics Committee which operates according to guidelines established by the National Health and Medical Research Council.

2. Research Projects which Require Approval

A principle contained in the NHMRC Statement on Human Experimentation is that all research involving human experimentation should be submitted for approval to an institutional ethics committee (IEC). The NHMRC Statement is to be read in conjunction with the Supplementary Notes. Supplementary Note I refines the principle and requires those research projects involving human subjects and relating to health to be approved by an appropriately constituted ethics committee.

There is a tendency to give `health' a broad definition so that it encompasses all research involving human participants. Therefore, projects which are not medical and do not involve human experimentation will nonetheless need to be appraised for their ethical acceptability if they involve human participants.

The need to conform to NHMRC principles is not restricted to research funded under NHMRC grants as the University has entered into an agreement with the NHMRC that **all** research within the University will be conducted in accordance with these principles including research activities emanating from the teaching program. However, the DUEC only conducts ethical reviews of research projects undertaken by staff members and masters by research and doctoral students. Application for ethical review of research projects/activities undertaken as part of undergraduate, honours year, masters prelim., graduate diploma or masters by coursework programs should be made to the relevant faculty ethics sub-committee.

3. The Application Form

Applications for ethical approval for a research project must be made on the DUEC Protocol form and be in type format. **Handwritten applications will not be accepted.** The application form is available on disk or via email from the Secretary, Academic Administration Support, AASD, Geelong. Ph: 273412, fax: 272789, email: keithwil

If a research grant application has been submitted to a funding body such as ARC/NHMRC, a copy should be attached to the ethics application. The grant application will be used to provide further information on the project if required, ***but copies will not be circulated to the members of Ethics Committee and the Ethics form should be completed without reference to the grant application.***

4. Timing of application

The Deakin University Ethics Committee meets six times per year and applications for approvals should be submitted to the Secretary by the relevant agenda deadline. Information on meeting dates and agenda deadlines is published annually in NETWORK and is also available from School administrative officers and the Secretary of the DUEC.

Staff/higher degree students whose research requires ethical clearance from an external IEC as well as the DUEC should apply to both committees simultaneously.

Staff members applying for research grants from funding bodies such as the ARC/NHMRC should make sure that their applications are submitted to the DUEC in time to obtain clearance by the required date. NB: It is advisable to apply in advance of the granting body's deadline to allow for any amendments which may be required by the DUEC.

Where ethical clearance is required for projects funded under the ARC Small Grants Scheme, application should be made to the DUEC as soon as the grant is announced as grant payments cannot commence until ethical clearance is obtained.

5. Ethical Issues

All research or teaching activities involving human subjects must conform to generally accepted moral and scientific principles and to the NHMRC Statement on Human Experimentation attached to these guidelines.* Researchers should also note the relevance of codes of ethical practice developed by their professional bodies.

The application should provide information on ethical issues including:

. the procedure for obtaining of informed consent of participants;

. degree of protection of privacy for personal information;

. source(s) of participants and sampling procedures;

. details of any proposed payment to be made, or course credit to be granted to participants. (Payment may be made for inconvenience or time spent, but should not be so large as to be an inducement to participate);

. details of research methods;

. use of invasive techniques or administration of drugs;
. details of any proposed communication of findings to the participants;

. the benefits to be gained from the work as compared with any discomfort or risks involved (why this study is worth doing);

. safety of equipment and procedures;

. training of those conducting the research in handling contingencies.

6. Classification of Project

All research projects involving participation of human subjects are classifiable under one of the categories described in Question 3 on the Ethics Protocol form unless the information to be acquired is a matter of public record. Applicants who answer all parts of Q3 negatively should be sure that they have done so correctly.

7. Procedures for Obtaining Informed Consent

a) The Plain Language Statement

Informed consent is based on the information provided in the plain language statement. The statement should be addressed to the participants rather than the DUEC and should be written in language which a layperson would understand. It is permissible for the statement to take the form of a letter to the participant. What is required is a short summary in simple language of the essential points which a reasonable person would want to know before agreeing to participate. The statement should include information on the following:

. aims of the project
. procedures involved
. time commitment expected of participants
. description of reasonably foreseeable risk or discomfort (if any)
. a statement describing the provisions to be made to preserve confidentiality of records
. the researcher's name and contact details.

For examples of satisfactory plain language statements see examples provided.

b) **The Consent Form**

Participants are normally required to give written consent before participating in a research study and three sample consent forms are attached to the Ethics Protocol form. The first is suitable for more invasive research or "human experimentation", the second for research involving surveys or questionnaires, and the third for consent on behalf of a minor. In some cases, consent will need to be witnessed eg. where the subject is blind/intellectually disabled. A witness must be independent of the project and may only sign a certification to the level of his/her involvement. A suggested format for witness certification is included with the sample consent forms. The form should also record the witnesses' signature, printed name and occupation.

The consent forms may be changed to suit the research study but the information contained in the pro forma must be included. The name of the person(s) undertaking the study and the purpose of the research should be added to the form. The latter does not constitute a plain language statement.

A copy of the plain language statement and the consent form(s) should be attached to the Ethics application. **The Plain Language Statement MUST include the relevant contact names and numbers of the principal investigator. Where the principal investigator is a student the Plain Language Statement MUST ALSO include the contact name and number of the chief supervisor.**

The plain language statement and consent form will normally be separate so that the subject may keep the statement and return the signed consent to the researcher. However, there will be occasions where it is appropriate to combine the two in the one document eg. the consent form may be produced as a tear-off section.

The researcher is not required to obtain signed consents from the subjects before applying for ethical clearance as the DUEC must consider the ethical implications of the research before the subjects are asked to participate.

Where research involves video taping of classroom activities parental consent will be required if the students could be identified from the video tape.

c) **Informed Consent and Deceptive Research**

There may be experimental procedures which would be defeated by the participants knowing in advance what was happening. When assessing the research protocol the DUEC will work to the following guidelines:

(i) the participants should not be subject in these situations to any procedure which is reasonably likely to prove either physically harmful to them or of enduring psychological harm (to be distinguished from mild alarm or temporary embarrassment); and

(ii) they are to be fully informed at the close of the experiment as to its nature, the disposition of results etc.

8. Permission to undertake Research in Schools

Where research is to be undertaken in a primary or secondary school, written permission should be obtained from the School Principal, and if appropriate, from the classroom teacher. Permission may be sought from the school before application is made to the DUEC. However, permission from the principal does not obviate the need to obtain parental consents where required by the DUEC. (See Guidelines for approval for Research in (Ministry) Schools.)

9. Interview Questions

Where a questionnaire has been developed this should be attached to the application for ethical clearance. Otherwise, the researcher should provide information on the nature of the interview questions and the way in which they will be asked in order for the DUEC to determine what ethical issues, if any, are raised by the proposed research.

10. Confidentiality

Precautions should be taken to protect the identity and privacy of subjects in a research project and it is not sufficient for a researcher to simply state that subjects' names will not be used when the data is written up. The DUEC needs to be satisfied with the provision made to preserve confidentiality of records. For example, where information is to be obtained through taped interviews, confidentiality is more likely to be preserved if the researcher numbers each tape and keeps a separate list of corresponding numbers and names; given names only or aliases should be used during taped interviews.

11. Storage of data

It should be noted the NHMRC procedures for the storage of data, make the principal investigator of an approved project responsible for the storage and _retention of original data pertaining to the project for a _minimum of five years.

Individual researchers should be able to hold copies of the data for their own use. However, original data should be retained in the School or research unit in which they were generated wherever possible.

Approved:
Deakin University Ethics Committee
9.8.1993
DUECGUID.ETH

* A copy may be obtained from the DUEC Secretary

Ext. 273412
Fax 272789
email keithwil

Enclosure (2)
MP-2.

MONASH UNIVERSITY

STANDING COMMITTEE ON ETHICS IN RESEARCH ON HUMANS (SCERH) APPLICATION FOR ETHICAL APPROVAL OF A PROJECT USING HUMANS

COVER PAGE

(This page MUST be fully completed)
DO NOT alter the formatting or pagination of this application form

APPLICATION NUMBER: ....
OFFICE USE ONLY

Project Title: ....
(limit to ten words)

1. **Chief Investigator(s)/Supervisor:** ....
(include title and department/location)

2. ....

3. **Co-Investigator/Student Researcher:** ....

4. ....

Contact Person: ....

(include department/full address/ telephone number/fax number)

a) **If applicable please give previous Monash University project number:** ....

b) **Type of Research:**

☐ Staff Research ☐ Class Project ☐ Other: ....

☐ Student Research - Name of degree: ....

c) **Have you applied for external funding?** ☐ Yes ☐ No

If YES, name granting body/bodies: ....
(Please attach the relevant pages from the grant application to this ethics application)

Has the funding been approved? ☐ Yes ☐ No ☐ Pending

d) **Has this project been submitted to any other Ethics Committees?** ☐ Yes ☐ No ☐ Pending
(see Question 4)?

If YES, name of Committee: ....

Has approval been granted? ☐ Yes ☐ No ☐ Pending
(Attach copy of the approval if available)

e) **Proposed Commencement Date for this Project:**..

Proposed Date of Completion for this Project:..

f) **Does the Privacy Act apply to this Project?** (refer Question 19) ☐ Yes ☐ No

g) **Does this Project involve the CTN Scheme clinical trials?** ☐ Yes ☐ No
If YES, please contact the Secretary to obtain the CTN application form and further details.

MONASH UNIVERSITY

AUSTRALIA

STANDING COMMITTEE ON ETHICS IN RESEARCH ON HUMANS (SCERH)

GUIDELINES AND APPLICATION FORM FOR ETHICAL APPROVAL OF A RESEARCH PROJECT USING HUMANS AS SUBJECTS

(Revised - January 1998)

Monash University has a central ethics committee – the Standing Committee on Ethics in Research on Humans (SCERH). All research conducted by Monash University staff or students involving humans must receive clearance from SCERH before commencing.

Historically the Monash SCERH is an NHMRC Committee. However, SCERH acknowledges that there are other environments in which university research is conducted, and that research methodologies vary in accordance with certain fields of study. The Committee has retained the NHMRC Principles in this application form. They affirm fundamental rights for participants/subjects in research and provide guidance in the conduct of research.

Although most research carried out by staff and students does not entail serious risks there may be some research projects where these may be present. The questions on this form are intended to assist SCERH to minimise risk to everyone, including the researcher(s) and the subject(s)/participant(s).

You will be able to begin your research after receiving official notification of ethical clearance by SCERH. Please note that SCERH does not grant retrospective approval of projects.

Instructions to applicants

- **Please answer all the questions**
- **Do not alter the formatting or pagination of this application form. If you require further space to answer any questions, please do so on p.13.**
- **Read the checklist (p.15) to ensure that all relevant documentation is attached to the application**
- **The application must be word processed or typewritten.** You can obtain a copy of the file on disk in Word for Windows by contacting the Secretary on 9905 2052. A copy of the form is also available on the World Wide Web at the following address http://www.monash.edu.au/resgrant/

See page 15 for further information concerning deadlines and submission procedures.

STANDING COMMITTEE ON ETHICS IN RESEARCH ON HUMANS

ADMINISTRATION

Research must conform to generally accepted moral and scientific principles. To this end, institutions in which human experimentation is undertaken should have a committee concerned with ethical aspects and all projects involving human experimentation should be submitted for approval by such a committee.

Protocols of proposed projects should contain a statement by the investigator of the ethical considerations involved.

Research should be conducted only by suitably qualified persons with appropriate competence, having facilities for the proper conduct of the work; clinical research requires not only clinical competence but also facilities for dealing with any contingencies that may arise.

Subject to maintenance of confidentiality in respect of individual patients, all members of research groups should be fully informed about projects on which they are working.

Do not alter the formatting or pagination of this application form. If you require further space to answer any questions, please do so on p.13.

1. SHORT PROJECT TITLE

....

(10 words or less. This exact title must appear on your Consent Form and Explanatory Statement. Use simple, non-technical words.)

APPLICANTS

Chief Investigator/Supervisor: ....

Co-Investigator/Student: ....

(Include your academic qualifications. SCERH assumes that the applicant will be ultimately responsible for the ethical conduct of the research. In the case of student research this responsibility is exercised by the supervisor.)

Contact Address: ....

....

....

.... Postcode: ....

Telephone numbers: .... (Work) .... (Home)

(The applicant should be readily available to answer queries)

Home campus: ....

3. RESEARCH SOURCE

Staff Research ☐

Have you applied for external funding? ☐ Yes ☐ No

Has funding been granted? ☐ Yes ☐ No ☐ Pending

Name of funding body: ....

Student Research ☐ **Towards which degree:** ....

Name and qualifications of supervisor: ....

....

4. RESEARCH REQUIRING ETHICAL CLEARANCE FROM OTHER INSTITUTIONS

(e.g. research on hospital patients or staff will require approval from that hospital's ethics committee)

Has this research project been submitted to any other ethics committees? ☐ Yes ☐ No

If NO, go to Q5.
If YES, please answer the following questions:

a) Name of committee:

....

b) Has ethical approval been granted? ☐ Yes ☐ No ☐ Pending

(If YES, please attach a copy of the letter of approval)

5. RESEARCH REQUIRING PERMISSION FROM OTHER ORGANISATIONS

If permission from an organisation is required, written advice **must** be submitted prior to commencement of the project.

(e.g. the Ministry of Education where research in government schools is proposed, school principals, or within commercial or government organisations)

Is permission required? ☐ Yes ☐ No

If NO, go to Question 6.
If YES, please answer the following questions:

a) From whom should permission be sought?

....

b) Has permission been granted? ☐ Yes ☐ No ☐ Pending

(If YES, please attach a copy of the letter of permission)

(If PENDING, SCERH may grant provisional ethical clearance, whereby research procedures may start as soon as permission documents have been officially received by SCERH)

6. PROPOSED DATE OF COMMENCEMENT OF PROJECT .... / .... / ....
ANTICIPATED DATE OF COMPLETION .... / .... / ....

INTRODUCTION

BACKGROUND AND AIMS OF THE RESEARCH PROJECT

The research protocol should demonstrate knowledge of the relevant literature and wherever possible be based on prior laboratory and animal experiments.

The investigator, after careful consideration and appropriate consultation, must be satisfied that the possible advantage to be gained from the work justifies any discomfort or risks involved.

7. GIVE A SUCCINCT DESCRIPTION OF THE BACKGROUND AND POTENTIAL SIGNIFICANCE OF THE RESEARCH PROJECT

(250 words or less. Attach a separate reference list if relevant.)

CLEARLY STATE THE AIMS AND/OR HYPOTHESES OF THE RESEARCH PROJECT

(250 words or less)

METHOD

SUBJECTS, MATERIALS AND PROCEDURES FOR THE RESEARCH PROJECT

9. DETAILS ABOUT THE SUBJECTS/PARTICIPANTS OF THE PROPOSED RESEARCH

In the conduct of research, the investigator must at all times respect the personality, rights, wishes, beliefs, consent and freedom of the individual subject.

Volunteers may be paid for inconvenience and time spent, but such payment should not be so large as to be an inducement to participate.

a) **How many people will be involved as subjects/participants?**
(NB: give upper and lower limits of sample size.)

....

....

b) **What categories of people?**
(e.g. teachers, undergraduate students, school children, epileptics, hospital patients, pensioners, etc)

....

....

c) **Age range:**

....

....

d) **Criteria for exclusion:**
(e.g. under 18-year-olds, pregnant women, people who have already experienced an experimental condition, etc., may be unsuitable participants in your research project)

....

....

e) **How much time are you asking of each subject/participant and when will the time be required?**
(e.g. during school hours)

....

....

....

f) **Are you offering any payment?** ☐ Yes ☐ No

If YES, give details:

....

....

....

10. RECRUITMENT

a) Who will be doing the recruitment of volunteers into the study?

....

....

....

....

....

b) Is there an external agent/external body/third person doing the recruitment for the researcher?
(e.g. professional associate, leisure group, church organisation)

☐ Yes ☐ No

c) What is the relationship between the recruiter and the subjects/participants?

....

....

....

....

d) Will any special relationship exist between the recruiter and the participants?
(A special relationship may exist if the person recruiting the participants holds some power over the participants in the research, e.g. counsellor/client, teacher/student, warder/prisoner, parent/child, customer/supplier, doctor/patient.)

☐ Yes ☐ No

If YES, describe the nature of the relationship, and explain what special precautions will preserve the rights of such people to decline to participate, or to withdraw from participation once the research has begun:

....

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e) How and where will the recruitment process occur?

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11. EXPLANATION PROCEDURES

Ethical practice requires the researcher to inform potential participants of all features of the research that might reasonably be expected to influence their willingness to participate in the project and to explain any other aspects of the project about which the potential participant asks.

Researchers should refer to the document 'Writing an Explanatory Statement', which includes a checklist and an example explanatory statement. This document can be downloaded separately from the web. Additional examples of statements as a reference are available by contacting the Secretary.

a) Who will be explaining the project to potential subjects/participants?

....

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b) How and where will the explanation take place?
(The safety of all parties needs to be assured. SCERH also needs to be assured that the participants are not placed in a potentially coercive situation.)

....

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....

c) Will subjects be fully informed about the true nature of the research?
(The researchers may not tell the participants the exact aim of the research. Certain types of research would be impossible if participants knew in advance what was happening.)

☐ Yes ☐ No

If NO, describe the procedure and explain why the real purpose needs to be concealed:

....

....

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12. INFORMED CONSENT PROCEDURES

Before research is undertaken, the free consent of the subjects should be obtained. To this end the investigator is responsible for providing the subject with sufficient information about the purpose, methods, demands, risks, inconveniences and discomforts of the study at his or her level of comprehension.

Consent should be obtained in writing unless there are good reasons to the contrary, and these reasons must be clearly stated below. If consent is not obtained in writing, the circumstances under which it is obtained should be recorded.

It must be made clear that the subject is free to withdraw consent to further participation at any time.

Special care must be taken in relation to consent, and to safeguarding individual rights and welfare where the research involves children, the mentally ill and those in dependant relationships or comparable situations.

a) **Attach the Consent Form(s) as an attachment to this submission, or explain why one is unnecessary, or inappropriate.**
Researchers should refer to the document 'Writing a Consent Form' for an outline of situations in which consent forms are not required, and for guidance on writing the forms themselves. This document can be downloaded separately from the web.

Consent Form attached? ☐ Yes ☐ No

If NO, the reason is:

....

....

....

....

b) **If the participants in your study will be unable to complete a Consent Form, explain how you intend to obtain the informed consent.**
(For young children or incapacitated participants, explain who will give consent on their behalf.)

....

....

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....

....

c) **Who will be available to act as an independent witness to subject's/participant's consent? If you feel that a witness is unnecessary, please explain why.**
(Independent means someone not associated with the research project. A witness to the subject's signature is advisable where subjects will be exposed to any level of risk beyond that normally encountered in everyday life.)

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13. USE OF EXISTING RECORDS WHICH ARE NOT IN THE PUBLIC DOMAIN

Are you intending to use existing records, which identify individuals, but which are not in the public domain?
(e.g. medical records, personal diaries, computer data, or any other information not available in a public library) ☐ Yes ☐ No

If NO, go to Question 14.
If YES, answer the following questions:

a) Describe the *type* of records to be used.
(e.g. medical records, personal diaries, computer data, etc.)

....

....

b) Which individuals or organisations control access to the information?

....

....

c) Is any organisation listed in (b) above a 'Commonwealth Agency'?
(i.e. any Commonwealth government department, any statutory agency created by Commonwealth legislation, any federal union or employer organisation, any non-statutory body set up by the Commonwealth, federal and ACT courts, and the Australian Federal Police)
☐ Yes ☐ No

d) Has the organisation agreed to provide the information?
☐ Yes ☐ No ☐ Pending
If YES, attach a copy of the letter.

e) State any conditions imposed by the organisation on the release of information:

....

....

....

f) Will you have access to identifying information about any individual?
(i.e. Will you be able, either directly or indirectly, to match names to the information or opinions contained in the records?) ☐ Yes ☐ No

If YES, will that individual's consent be sought by the researcher?
☐ Yes ☐ No

If NO, please give reasons, and show how such participants will be protected from having identifying information made public.

....

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....

NB: If you have answered YES to both 13(c) and 13(f), the Privacy Act WILL apply, so please answer YES to Question 19.

14. COLLECTION OF DATA - MATERIALS AND PROCEDURES

a) Is there any special relationship between the person administering the test or procedure and the participant?

☐ Yes ☐ No

If YES, describe the nature of the relationship:

....

....

....

....

b) What techniques or methods of data collection and other measurement will be used? Researchers should briefly outline all research/control procedures to be used with each category of subjects/participants?
(e.g. questionnaires, interviews, video and taped interviews, observation, involvement in a clinical drug trial as a subject or control)

....

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....

....

c) Where will these procedures take place?

....

....

....

....

d) Does the research involve the administration of any tests or other procedures that can only be used by people with particular qualifications?
(e.g. certain psychological tests, medical tests) ☐ Yes ☐ No

If YES, give details of the test or procedure, qualifications required, proposed administrator and qualifications:

....

....

....

....

e) Will radioactive substances, recombinant DNA techniques, toxins, mutagens, teratogens or carcinogens be used? ☐ Yes ☐ No

If YES, specify which:

....

....

(If YES, submit evidence of clearance by University Radiation Protection Officer, and/or the Biosafety Committee)

Evidence submitted with application? ☐ Yes ☐ No ☐ Pending

15. COLLECTION OF DATA - RISKS AND PROCEDURES

New therapeutic or experimental procedures which are at the stage of early evaluation and which may have long-term effects should not be undertaken unless appropriate provision has been made for long-term care, observation and maintenance of records.

The investigator must stop or modify the research program or experiment if it becomes apparent during the course of it that continuation may be harmful.

a) **Define the risk of physical/psychological stress, inconvenience or discomfort beyond the normal experience of everyday life, in either the short or long term, from participation in the project.**

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b) **Are all of these risks outlined on the consent form? If not, why not?**

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c) **Outline the arrangements planned to minimise the risks involved in these procedures.**

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d) **Should serious events or emergencies occur during the conduct of the research what will you do? What facilities are available to deal with such incidents?**
(e.g. an adverse drug reaction, subject/participant becomes distressed during questioning)

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e) **What will the researcher do if, in the course of the research, highly sensitive information, or information about the subject's well-being is disclosed?**
(eg. subject suggests: domestic abuse, potential suicide, substance abuse, HIV +, involved in crime)

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f) **Is the project to be conducted by researchers who are mandated by law to report certain findings?** (*e.g. certain infections, child abuse, domestic violence*) ☐ Yes ☐ No
If YES, this information must be included in the Explanatory Statement.

16. DEBRIEFING PROCEDURES

Is a debriefing appropriate or necessary for the subjects/participants? ☐ Yes ☐ No

If NO, go to question 17.
If YES, answer the following questions:

a) How will information about results of any tests be communicated to subjects/participants?

....

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....

b) What arrangements will be in place to deal with subjects'/participants' distress in the case of adverse test results?

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17. CONFIDENTIALITY AND SECURITY PROCEDURES

(Researchers should avoid causing their subjects distress or harm from breaches of confidentiality.)

The Monash University Code of Conduct for the Responsible Practice of Research places obligations upon researchers (refer Part 3, Research Policy **Monash University Education and Research Policy**).

a) University regulations require the following procedures concerning storage of data:

i) Only the researchers will have access to the original data ☐
ii) Data will be retained in the Department for five years ☐
iii) Original data or electronically stored copies of the original data, may be destroyed after five years ☐

b) If the above regulations are not being adhered to, how will information be handled to safeguard confidentiality?

....

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....

c) Describe the procedures you will use to protect participants from any distress, embarrassment or other harm that might be caused when the data is reported.

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18. ARE THERE ANY OTHER ETHICAL ISSUES RAISED BY THE PROPOSED PROJECT? WHAT IS YOUR RESPONSE TO THEM?

In many research projects involving humans there is a trade-off to be made between the cost of the interventions to those participating in them *(e.g. in terms of discomfort, health risk, loss of privacy, etc)* and the value to be achieved by carrying out the research. The Committee must be in a position to evaluate clearly that trade-off.

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This space is to be used should you need to add further detail to any response made earlier on this application form:

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SIGNATURES

19. STATUTORY PRIVACY PROTECTION

If the data used are held or to be collected by a Commonwealth Agency (see Question 13(c)) AND collection will or might enable identification of any individual (see Question 13(f)), then the Privacy Act (1988) applies.

Does the Privacy Act apply to the proposed data collection? ☐ Yes ☐ No

....

Signature of Chief Investigator/Supervisor **Date**

20. DECLARATION

I/We, the undersigned, accept responsibility for the conduct of the research detailed above, the principles outlined above and any other condition noted by the SCERH. If any changes to the protocol are proposed after the approval of the Committee has been obtained then SCERH will be informed immediately. The Associate Investigator will assume responsibility for the project in the absence of the Chief Investigator.

Signature of Chief Investigator/or Supervisor

Name: .... *(please print)*

Signature: .... Date: ....

Signature/s of Co-Investigator(s)/Student Researcher

1. Name: .... *(please print)*

Signature: .... Date: ....

2. Name: .... *(please print)*

Signature: .... Date: ....

Signature of Head of Department

I certify that I am prepared to have this project undertaken within my Department.

Name: .... *(please print)*

Signature: .... Date: ....

Section: ....

21. CHECKLIST

Please ensure that those items listed below which are relevant to your application are attached to the application. **Failure to do so will hinder the approval procedure.** This sheet **must** be submitted with the application. Please type "N/A" if not applicable. Every box should be either checked or marked N/A.

☐ Original plus three copies provided to the Secretary, SCERH (address below)

☐ All details on SCERH Cover Sheet completed

☐ If external funding is being provided, relevant pages from the grant application must be submitted

☐ Q.5 - Copy of written advice from other organisations from whom approval must be sought

☐ Q.7 & Q.8 - Reference materials

☐ Q.10 - Copy of posters/announcements to be used to recruit participants into the study

☐ Q.11 - Explanatory Statement(s)

☐ Q.12 - Consent Form(s)

☐ Q.13 - Copy of written permission to use information in records which are not in the public domain

☐ Q.14 - Copy of data collection materials (questionnaires, interview schedules or specifications of instruments) should be attached

☐ Q.14 - If radioactive substances, recombinant DNA techniques, toxins, mutagens, teratogens or carcinogens are to be used, researchers should submit evidence of clearance by a University Radiation Protection Officer, and/or the Biosafety Committee

☐ Q.15 - Copy of written advice from other groups who have agreed to follow-up should any participant require assistance due to taking part in the research.

☐ Q.16 - Where post-research de-briefing is offered, a copy of this information should be provided.

☐ Q.19 - If the Privacy Act applies (refer Q.13c & Q.13f), then the Privacy Declaration should be signed.

☐ Q.20 - Have the researchers signed the Declaration concerning responsibility for the research project?

☐ Q.20 - Has the Head of Department/Faculty also signed this Declaration?

Mail or deliver the **ORIGINAL PLUS THREE** hard copies of your application to:

Secretary
Standing Committee on Ethics in Research on Humans (SCERH)
Research Grants and Ethics Branch
Monash University
Wellington Road
CLAYTON VIC 3168

Deadlines

SCERH will meet every three weeks from February to December in 1998 – 16 meetings are scheduled. To be considered at a particular meeting, applications should be received by the Secretary three weeks before that meeting. However, applications may be forwarded at **any** time as deadlines are of little concern given the frequency of meetings. Please contact the Secretary for meeting dates (Ph: 9905 2052).

Writing a Consent Form

Subjects/participants under 18 years of age should be asked to give written consent to involvement in the project if they are of an age and/or intellectual ability where they can understand the proposed procedures.

Where projects involve any level of risk to participants beyond that encountered in everyday life, an independent witness should also be present to sign the consent form.

If any potential subjects are under 18 years of age or are people over 18 who are unable to reach an informed decision about participation, additional, separate consent forms are needed for parents/guardians.
(ie/ For research on children, the mentally ill, those in dependent relationships or comparable situations, including unconscious patients).

Consent forms are only unnecessary where consent is implied (eg: anonymous return of questionnaires by mail).

How to write your Consent Form(s) for your research project

Consent Forms may be produced on plain paper rather than letterhead, as they are collected and retained by the researchers. Explanatory Statements, on the other hand, are kept by the subject, so they need to be on Monash letterhead which provides corporate identity and address details.

Attached is a suggested format for consent forms. This is only intended as a guide, and variations on this format are acceptable.

Informed Consent Form

Project Title: (Exactly as it appears on your SCERH Application Form)

I agree to take part in the above Monash University research project. I have had the project explained to me, and I have read and understood the Explanatory Statement, which I retain for my records.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I also understand that my participation is voluntary, that I can choose not to participate, and that I can withdraw my participation at any stage of the project.

Name: .... (please print)

Signature: .... Date: ....

Independent witness to participant's voluntary and informed consent:

Name: ....(please print)

Signature: .... Date: ....

Address:..

Informed Consent Form for Parents/Guardians of Project Participants

I agree that ....(full name of participant) may take part in the above Monash University research project. The project has been explained to .... and to me, and I have read and understood the Explanatory Statement, which I retain for my records.

understand that any information provided by .... is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I also understand that ....'s participation in the project is voluntary, that s/he can refuse to participate, and that s/he can withdraw her/his participation at any stage.

Participant's Name: .... (please print) Participant's Age:......................

Parent's/Guardian's Name: ....

Your relationship to participant:

....

If appropriate, reason(s) why s/he cannot give written consent:

....

....

Writing an Explanatory Statement

The explanatory statement should be designed so that potential participants of your research project can give **informed consent** to participate in the project.

The items listed below should be used as a guide as to what information is required in the statement. *This list is for your own reference.* ***Do not*** *submit this with the application form.* See the following page for an example of how to design an explanatory statement.

◊ *Does you explanatory statement meet the following criteria:*

☐ Clear identification of the University as the responsible institution (normally use letterhead)

☐ The short title of the project *exactly* as it appears on your SCERH application form, name of chief investigator(s) and any other person who will have direct involvement with research subjects

☐ A statement of the purpose of the study, the inclusion and exclusion criteria and alternative treatments available (where appropriate)

☐ A description of the possible benefits for participants and/or society in general

☐ An outline of *all* methods or procedures involving the potential participant

☐ An indication of the expectations of the potential participant: time involved, level of inconvenience and/or discomfort and any payment offered

☐ A list of all possible or reasonably foreseeable risks of harm or possible side effects to the potential participant (outlining likely incidence and severity) and contact details of someone who will answer any inquiries about the research.

☐ A statement about how you will discharge your responsibility to protect the subjects' rights to privacy.

☐ A statement of where the records will be stored and details of access and discard.

☐ A clear statement that participation is voluntary, that subjects may withdraw at any stage, or avoid answering questions which are felt too personal or intrusive, and an assurance that this will not affect future treatment

☐ An indication of whether participants will be informed of overall results, or any which might affect them personally, and what debriefing procedures are available for those who withdraw (where appropriate)

☐ The name and phone number of someone who can be contacted in an emergency or if the participant has any concerns (this should not normally be a home phone number)

☐ The University complaints clause:

Should you have any complaint concerning the manner in which this research is conducted, please do not hesitate to contact The Standing Committee on Ethics in Research on Humans at the following address:

The Secretary
The Standing Committee on Ethics in Research on Humans
Monash University
Wellington Road
Clayton Victoria 3168
Telephone (03) 9905 2052 Fax (03) 9905 1420

◊ Is it written in language that potential participants could reasonably be expected to understand?

◊ Is it free from coercive language or promises that cannot be kept?

MONASH UNIVERSITY

AUSTRALIA

Date

Project Title: (<u>Exactly</u> as it appears on your SCERH Application Form)

My name is ______________________ and I am studying for my ____________________ (eg GradDip, BSc (Honours), MA etc) at Monash University. A research project is an important component of the course and I am undertaking mine under the supervision of ________________________ (eg Dr..........) a ________________ (eg lecturer/senior lecturer/professor etc) in the Department of ____________________.

The aim of this project is to ____________________________________ (eg explore the relationship between a Quality Culture and job satisfaction. Quality Culture, sometimes referred to as TQM or TQC is becoming a major part of business practice and it is important to be able to measure it and research its effectiveness. Employee satisfaction is also critical to business performance). I believe that the findings of this research project will be useful ________________________ (eg in contributing to knowledge in these areas).

I am seeking ________________________ (eg adults in full employment) who are prepared to _______________ (eg fill out the attached questionnaire on their organisation's practices and their own job satisfaction). (Consequently, if you are ______________________ (eg under 18 years of age) or _____________ (eg unemployed), you are unable to participate in this research project.) The procedure would take approximately ____________________ (eg thirty minutes) of your time, and would be undertaken at ____________ (eg home, at your convenience).

No findings will be published which could identify any individual participant. Anonymity is assured by our procedure, in which ____________________ (eg you are not asked to provide either your name or the name of your organisation on your questionnaire response sheet.) Access to data is restricted to my supervisor and to me. Coded data are stored for five years, as prescribed by University regulations.

Participation in this research is entirely voluntary, and if you agree to participate, you may withdraw your consent at any time by __________________ (eg not returning the questionnaire) or decline to participate in any section of the procedure, by __________________ (eg simply not marking a response).

If you have any queries or would like to be informed of the aggregate research finding, please contact telephone __________ fax ___________ (This must be a university address/telephone/fax not a personal contact number)

Thank you.

Should you have any complaint concerning the manner in which this research is conducted, please do not hesitate to contact The Standing Committee on Ethics in Research on Humans at the following address:

The Secretary
The Standing Committee on Ethics in Research on Humans
Monash University
Wellington Road
Clayton Victoria 3168
Telephone (03) 9905 2052 Fax (03) 9905 1420

____________________________ (your signature)

(Distribute photocopies to potential participants; use of original letterhead is unnecessary)

____________________________ (your typed name)

____________________________ (your phone number)

REVISED 6.3.98

Enclosure(3)

Broad AUSTRALIAN Guidelines

c̄ Sample Ethical Approval forms.

APPENDIX 2

NHMRC STATEMENT ON HUMAN EXPERIMENTATION

Aware of the Declaration of Helsinki, adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, revised by the 29th World Medical Assembly, Tokyo, Japan, 1975, and the 35th World Medical Assembly, Venice, Italy, 1993 and of the Proposed International Guidelines for Biomedical Research Involving Human Subjects published by the World Health Organisation and the Council for International Organisations of Medical Sciences in 1982, the National Health and Medical Research Council issues the following Statement on Human Experimentation. *These are intended as a guide on ethical matters bearing on human experimentation, for research workers and administrators of institutions in which research on humans is undertaken in Australia.

* The Statement is associated with the following Supplementary Notes in a document which is available from Administrative Officers in research institutions or from the NHMRC Secretariat or Publications:

Supplementary Note 1- Institutional Ethics Committees

Supplementary Note 2 - Research on Children, the Mentally ill, Those in Dependent or Comparable Situations (Including Unconscious Patients)

Supplementary Note 3 - Clinical Trials

Supplementary Note 4 - In vitro Fertilisation and Embryo Transfer

Supplementary Note 5 - Research involving the Human Fetus and the Use of Human Fetal Tissue

Supplementary Note 6 - Epidemiological Research

Supplementary Note 7.- Somatic Cell Gene Therapy

NHMRC STATEMENT ON HUMAN EXPERIMENTATION

(To be read in conjunction with the Supplementary Notes)

The collection of data from planned experimentation on human beings is necessary for the improvement of human health. Experiments range from those undertaken as a part of patient care to those undertaken either on patients or on healthy subjects for the purpose of contributing to knowledge and include investigations on human behaviour. Investigators have ethical and legal responsibilities toward their subjects and should therefore observe the following principles:

(1) The research must conform to generally accepted moral and scientific principles. To this end institutions in which human experimentation is undertaken should have a committee concerned with ethical aspects and all projects involving human experimentation should be submitted for approval by such a committee. (See Supplementary Note 1: Institutional Ethics Committees).

(a) An application to the NHMRC for a research grant involving human experimentation is required to be certified by the ethics committee of the applicant's institution as complying with the NHMRC Statement on Human Experimentation and the Supplementary Notes before the application will be considered for funding.

(b) Persons undertaking human experimentation who are not associated with an institution should ensure that comments on their protocols are sought from an established ethics committee eg. in a university or hospital.

(2) Protocols of proposed projects should contain a statement by the investigator of the ethical considerations involved.

(3) The investigator, after careful consideration and appropriate consultation, must be satisfied that the possible advantage to be gained from the work justifies any discomfort or risks involved.

(4) The research protocol should demonstrate knowledge of the relevant literature and, wherever possible, be based on prior laboratory and animal experiments.

(5) In the conduct of research, the investigator must at all times respect the personality, rights, wishes, belief, consent and freedom of the individual subject.

(6) Research should be conducted only by suitably qualified persons with appropriate competence having facilities for the proper conduct of the work; clinical research requires not only clinical competence but also facilities for dealing with any contingencies that may arise.

(7) New therapeutic or experimental procedures which are at the stage of early evaluation and which may have long-term effects should not be undertaken unless appropriate provision has been made for long-term care, observation and maintenance of records.

(8) Before research is undertaken the free consent of the subject should be obtained. To this end the investigator is responsible for providing the subject at his or her level or comprehension with sufficient information about the purpose, methods, demands, risks, inconveniences and discomforts of the study. Consent should be obtained in writing unless there are good reasons to the contrary. If consent is not obtained in writing the circumstances under which it is obtained should be recorded

(9) The subject must be free at any time to withdraw consent to further participation.

(10) Special care must be taken in relation to consent and to safeguarding individual rights and welfare where the research involves children, the mentally ill and those in dependant relationships or comparable situations. [See Supplementary Note 2: Research on Children, the Mentally ill and Those in Dependant Relationships or Comparable Situations (Including Unconscious patients)].

(11) The investigator must stop or modify the research program or experiment if it becomes apparent during the course of it that continuation may be harmful.

(12) Subject to maintenance of confidentiality in respect of individual patients, all members of research groups should be fully informed about projects on which they are working.

(13) Volunteers may be paid for inconvenience and time spent, but such payment should not be so large as to be an inducement to participate.

APPENDIX 3

STATEMENT ON ANIMAL EXPERIMENTATION

The policy of the National Health and Medical Research Council regarding animal experimentation and the production, provision and care of experimental animals is set out in detail in the publication *Australian Code of Practice For The Care and Use of Animals For Scientific Purposes* which is sponsored jointly by the NHMRC, the CSIRO and the Agricultural Council of Australia and New Zealand.

Applicants for NHMRC grants must accept the following guidelines and are referred to the above publication for further details. These guidelines are based on the principle that animals are to be treated with respect and care, and that consideration of their welfare is an essential factor in determining their use in experiments. Accordingly, animal experimentation should be performed only to obtain and establish significant scientific information relevant to the understanding of humans and animals, to animal production, to the continued maintenance and improvement of the health and well-being of humans and animals, or to achieve educational objectives where the use of animals is unavoidable.

GENERAL PRINCIPLES FOR THE CARE AND USE OF ANIMALS FOR SCIENTIFIC PURPOSES

For the guidance of Investigators, Institutions and Animal Experimentation Ethics Committees and all involved in the care use of animals for scientific purposes.

(1) Experiments on animals may be performed only when they are essential to obtain and establish significant information relevant to the understanding of humans or animals, to the maintenance and improvement of human or animal health and welfare, to the improvement of animal management or production, or to the achievement of educational objectives.

(2) People who use animals for scientific purposes have an obligation to treat the animals with respect and to consider their welfare as an essential factor when planning and conducting experiments.

(3) Investigators have direct and ultimate responsibility for all matters relating to the welfare of the animals they use in experiments.

(4) Techniques which replace or complement animal experiments must be used wherever possible.

(5) Experiments using animals may be performed only after a decision has been made that they are justified, weighing the scientific or educational value of the experiments against the potential effects on the welfare of the animals.

(6) Animals chosen must be of an appropriate species with suitable biological characteristics including behavioural characteristics, genetic constitution and nutritional, microbiological and general health status.

(7) Animals must not be taken from their natural habitats if animals bred in captivity are available and suitable.

(8) Experiments must be scientifically valid, and must use no more than the minimum number of animals needed.

(9) Experiments must use the best available scientific techniques and must be carried out only by persons competent in the procedures they perform.

(10) Experiments must not be repeated unnecessarily.

(11) Experiments must be as brief as possible.

(12) Experiments must be designed to avoid pain or distress to animals. If this is not possible, pain or distress must be minimised

(13) Pain and distress cannot be evaluated easily in animals and therefore investigators must assume that animals experience pain in a manner similar to humans. Decisions regarding the animals welfare must be based on this assumption unless there is evidence to the contrary.

(14) Experiments which may cause pain or distress of a kind and degree for which anaesthesia would normally be used in medical or veterinary practice must be carried out using anaesthesia appropriate to the species and the procedure. When it is not possible to use anaesthesia, such as in certain toxicological or animal production experiments or in animal models of disease, the end-point of the experiments must be as early as possible to avoid or minimise pain or distress to the animals.

(15) Investigators must avoid using death as an experimental end-point whenever possible.

(16) Analgesic and tranquilliser usage must be appropriate for the species and should at least parallel usage in medical or veterinary practice.

(17) An animal which develops signs of pain or distress of a kind and degree not predicted in the proposal must have the pain or distress alleviated promptly. If severe pain cannot be alleviated without delay, the animal must be killed humanely forthwith. Alleviation of such pain or distress must take precedence over finishing an experiment.

(18) Neuromuscular blocking agents must not be used without appropriate general anaesthesia, except in animals where sensory awareness has been eliminated. If such agents are used, continuous or frequent intermittent monitoring of paralysed animals is essential to ensure that the depth of anaesthesia is adequate to prevent pain or distress.

(19) Animals must be transported, housed, fed, watered, handled and used under conditions which are appropriate to the species and which ensure a high standard of care.

(20) Institutions using animals for scientific purposes must establish Animal Experimentation Ethics Committees (AEECs) to ensure that all animal use conforms with the standards of this Code.

(21) Investigators must submit written proposals for all animal experimentation to an AEEC which must take into account the expected value of the knowledge to be gained, the validity of the experiments and all ethical and animal welfare aspects.

(22) Experiments must not commence until written approval has been obtained from the AEEC.

(23) The care and use of animals for all scientific purposes in Australia must be in accord with this Code of Practice and with Commonwealth, State and Territory legislation.

Mp-2.

OPRR Reports

NIH PHS HHS

The Belmont Report

Ethical Principles and Guidelines for the Protection of Human Subjects of Research

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

April 18, 1979

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of the Secretary

Protection of Human Subjects

Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

AGENCY: Department of Health, Education, and Welfare.

ACTION: Notice of Report for Public Comment.

SUMMARY: On July 12, 1974, the National Research Act (Pub. L. 93-348) was signed into law, there-by creating the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One of the charges to the Commission was to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure that such research is conducted in accordance with those principles. In carrying out the above, the Commission was directed to consider: (i) the boundaries between biomedical and behavioral research and the accepted and routine practice of medicine, (ii) the role of assessment of risk-benefit criteria in the determination of the appropriateness of research involving human subjects, (iii) appropriate guidelines for the selection of human subjects for participation in such research and (iv) the nature and definition of informed consent in various research settings.

The Belmont Report attempts to summarize the basic ethical principles identified by the Commission in the course of its deliberations. It is the outgrowth of an intensive four-day period of discussions that were held in February 1976 at the Smithsonian Institution's Belmont Conference Center supplemented by the monthly deliberations of the Commission that were held over a period of nearly four years. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects. By publishing the Report in the **Federal Register,** and providing reprints upon request, the Secretary intends that it may be made readily available to scientists, members of Institutional Review Boards, and Federal employees. The two-volume Appendix, containing the lengthy reports of experts and specialists who assisted the Commission in fulfilling this part of its charge, is available as DHEW Publication No. (OS) 78–0013 and No. (OS) 78–0014, for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Unlike most other reports of the Commission, the Belmont Report does not make specific recommendations for administrative action by the Secretary of Health, Education, and Welfare. Rather, the Commission recommended that the Belmont Report be adopted in its entirety, as a statement of the Department's policy. The Department requests public comment on this recommendation.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research

Members of the Commission

Kenneth John Ryan, M.D., Chairman, Chief of Staff, Boston Hospital for Women.
Joseph V. Brady, Ph.D., Professor of Behavioral Biology, Johns Hopkins University.
Robert E. Cooke, M.D., President, Medical College of Pennsylvania.
Dorothy I. Height, President, National Council of Negro Women, Inc.
Albert R. Jonsen, Ph.D., Associate Professor of Bioethics, University of California at San Francisco.
Patricia King, J.D., Associate Professor of Law, Georgetown University Law Center.
Karen Lebacqz, Ph.D., Associate Professor of Christian Ethics, Pacific School of Religion.
*David W. Louisell, J.D., Professor of Law, University of California at Berkeley.
Donald W. Seldin, M.D., Professor and Chairman, Department of Internal Medicine, University of Texas at Dallas.
Eliot Stellar, Ph.D., Provost of the University and Professor of Physiological Psychology, University of Pennsylvania.
*Robert H. Turtle, LL.B., Attorney, VomBaur, Coburn, Simmons & Turtle, Washington, D.C.

*Deceased.

Table of Contents

Belmont Report

Ethical Principles and Guidelines for Research Involving Human Subjects

Scientific research has produced substantial social benefits. It has also posed some troubling ethical questions. Public attention was drawn to these questions by reported abuses of human subjects in biomedical experiments, especially during the Second World War. During the Nuremberg War Crime Trials, the Nuremberg code was drafted as a set of standards for judging physicians and scientists who had conducted biomedical experiments on concentration camp prisoners. This code became the prototype of many later codes[1] intended to assure that research involving human subjects would be carried out in an ethical manner.

The codes consist of rules, some general, others specific, that guide the investigators or the reviewers of research in their work. Such rules often are inadequate to cover complex situations; at times they come into conflict, and they are frequently difficult to interpret or apply. Broader ethical principles will provide a basis on which specific rules may be formulated, criticized and interpreted.

Three principles, or general prescriptive judgments, that are relevant to research involving human subjects are identified in this statement. Other principles may also be relevant. These three are comprehensive, however, and are stated at a level of generalization that should assist scientists, subjects, reviewers and interested citizens to understand the ethical issues inherent in research involving human subjects. These principles cannot always be applied so as to resolve beyond dispute particular ethical problems. The objective is to provide an analytical framework that will guide the resolution of ethical problems arising from research involving human subjects.

This statement consists of a distinction between research and practice, a discussion of the three basic ethical principles, and remarks about the application of these principles.

A. Boundaries Between Practice and Research

It is important to distinguish between biomedical and behavioral research, on the one hand, and the practice of accepted therapy on the other, in order to know what activities ought to undergo review for the protection of human subjects of research. The distinction between research and practice is blurred partly because both often occur together (as in research designed to evaluate a therapy) and partly because notable departures from standard practice are often called "experimental" when the terms "experimental" and "research" are not carefully defined.

For the most part, the term "practice" refers to interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment or therapy to particular individuals.[2] By contrast, the term "research" designates an activity designed to test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships). Research is usually described in a formal protocol that sets forth an objective and a set of procedures designed to reach that objective.

When a clinician departs in a significant way from standard or accepted practice, the innovation does not, in and of itself, constitute research. The fact that a procedure is "experimental," in the sense of new, untested or different, does not automatically place it in the category of research. Radically new procedures of this description should, however, be made the object of formal research at an early stage in order to determine whether they are safe and effective. Thus, it is the responsibility of medical practice committees, for example, to insist that a major innovation be incorporated into a formal research project.[3]

Research and practice may be carried on together when research is designed to evaluate the safety and efficacy of a therapy. This need not cause any confusion regarding whether or not the activity requires review; the general rule is that if there is any element of research in an activity, that activity should undergo review for the protection of human subjects.

B. Basic Ethical Principles

The expression "basic ethical principles" refers to those general judgments that serve as a basic justification for the many particular ethical prescriptions and evaluations of

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[1] Since 1945, various codes for the proper and responsible conduct of human experimentation in medical research have been adopted by different organizations. The best known of these codes are the Nuremberg Code of 1947, the Helsinki Declaration of 1964 (revised in 1975), and the 1971 Guidelines (codified into Federal Regulations in 1974) issued by the U.S. Department of Health, Education, and Welfare Codes for the conduct of social and behavioral research have also been adopted, the best known being that of the American Psychological Association, published in 1973.

[2] Although practice usually involves interventions designed solely to enhance the well-being of a particular individual, interventions are sometimes applied to one individual for the enhancement of the well-being of another (e.g., blood donation, skin grafts, organ transplants) or an intervention may have the dual purpose of enhancing the well-being of a particular individual, and, at the same time, providing some benefit to others (e.g., vaccination, which protects both the person who is vaccinated and society generally). The fact that some forms of pratice have elements other than immediate benefit to the individual receiving an intervention, however, should not confuse the general distinction between research and practice. Even when a procedure applied in practice may benefit some other person, it remains an intervention designed to enhance the well-being of a particular individual or groups of individuals; thus, it is practice and need not be reviewed as research.

[3] Because the problems related to social experimentation may differ substantially from those of biomedical and behavioral research, the Commission specifically declines to make any policy determination regarding such research at this time. Rather, the Commission believes that the problem ought to be addressed by one of its successor bodies.

human actions. Three basic principles, among those generally accepted in our cultural tradition, are particularly relevant to the ethics of research involving human subjects: the principles of respect for persons, beneficence and justice.

1. *Respect for Persons.*—Respect for persons incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.

An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person's considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

However, not every human being is capable of self-determination. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. Respect for the immature and the incapacitated may require protecting them as they mature or while they are incapacitated.

Some persons are in need of extensive protection, even to the point of excluding them from activities which may harm them; other persons require little protection beyond making sure they undertake activities freely and with awareness of possible adverse consequences. The extent of protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations.

In most cases of research involving human subjects, respect for persons demands that subjects enter into the research voluntarily and with adequate information. In some situations, however, application of the principle is not obvious. The involvement of prisoners as subjects of research provides an instructive example. On the one hand, it would seem that the principle of respect for persons requires that prisoners not be deprived of the opportunity to volunteer for research. On the other hand, under prison conditions they may be subtly coerced or unduly influenced to engage in research activities for which they would not otherwise volunteer. Respect for persons would then dictate that prisoners be protected. Whether to allow prisoners to "volunteer" or to "protect" them presents a dilemma. Respecting persons, in most hard cases, is often a matter of balancing competing claims urged by the principle of respect itself.

2. *Beneficence.*—Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term "beneficence" is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation. Two general rules have been formulated as complementary expressions of beneficent actions in this sense: (1) do not harm and (2) maximize possible benefits and minimize possible harms.

The Hippocratic maxim "do no harm" has long been a fundamental principle of medical ethics. Claude Bernard extended it to the realm of research, saying that one should not injure one person regardless of the benefits that might come to others. However, even avoiding harm requires learning what is harmful; and, in the process of obtaining this information, persons may be exposed to risk of harm. Further, the Hippocratic Oath requires physicians to benefit their patients "according to their best judgment." Learning what will in fact benefit may require exposing persons to risk. The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks.

The obligations of beneficence affect both individual investigators and society at large, because they extend both to particular research projects and to the entire enterprise of research. In the case of particular projects, investigators and members of their institutions are obliged to give forethought to the maximization of benefits and the reduction of risk that might occur from the research investigation. In the case of scientific research in general, members of the larger society are obliged to recognize the longer term benefits and risks that may result from the improvement of knowledge and from the development of novel medical, psychotherapeutic, and social procedures.

The principle of beneficence often occupies a well-defined justifying role in many areas of research involving human subjects. An example is found in research involving children. Effective ways of treating childhood diseases and fostering healthy development are benefits that serve to justify research involving children—even when individual research subjects are not direct beneficiaries. Research also makes is possible to avoid the harm that may result from the application of previously accepted routine practices that on closer investigation turn out to be dangerous. But the role of the principle of beneficence is not always so unambiguous. A difficult ethical problem remains, for example, about research that presents more than minimal risk without immediate prospect of direct benefit to the children involved. Some have argued that such research is inadmissible, while others have pointed out that this limit would rule out much research promising great benefit to children in the future. Here again, as with all hard cases, the different claims covered by the principle of beneficence may come into conflict and force difficult choices.

3. *Justice.*—Who ought to receive the benefits of research and bear its burdens? This is a question of justice, in the sense of "fairness in distribution" or "what is deserved." An injustice occurs when some benefit to which a person is entitled is denied without good reason or when some burden is imposed unduly. Another way of conceiving the principle of justice is that equals ought to be treated equally. However, this statement requires explication. Who is equal and who is unequal? What considerations justify departure from equal distribution? Almost all commentators allow that distinctions based on experience, age, deprivation, competence, merit and position do sometimes constitute criteria justifying differential treatment for certain purposes. It is necessary, then, to explain in what respects people should be treated equally. There are several widely accepted formulations of just ways to distribute burdens and benefits. Each formulation mentions some relevant property on the basis of which burdens and benefits should be distributed. These formulations are (1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.

Questions of justice have long been associated with social practices such as punishment, taxation and political representation. Until recently these questions have not generally been associated with scientific research. However, they are foreshadowed even in the earliest reflections on the ethics of research involving human subjects. For example, during the 19th and early 20th centuries the burdens of serving as research subjects fell largely upon poor ward patients, while the benefits of improved medical care flowed primarily to private patients. Subsequently, the exploitation of unwilling prisoners as research subjects in Nazi concentration camps was condemned as a particularly flagrant injustice. In this country, in the 1940's, the Tuskegee syphilis study used disadvantaged, rural black men to study the untreated course of a disease that is by no means confined to that population. These subjects were deprived of demonstrably effective treatment in order not to interrupt the project, long after such treatment became generally available.

Against this historical background, it can be seen how conceptions of justice are relevant to research involving human subjects. For example, the selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

C. Applications

Applications of the general principles to the conduct of research leads to consideration of the following requirements: informed consent, risk/benefit assessment, and the selection of subjects of research.

1. *Informed Consent.*—Respect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided when adequate standards for informed consent are satisfied.

While the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent. Nonetheless, there is widespread agreement that the consent process can be analyzed as containing three elements: information, comprehension and voluntariness.

Information. Most codes of research establish specific items for disclosure intended to assure that subjects are given sufficient information. These items generally include: the research procedure, their purposes, risks and anticipated benefits, alternative procedures (where therapy is involved), and a statement offering the subject the opportunity to ask questions and to withdraw at any time from the research. Additional items have been proposed, including how subjects are selected, the person responsible for the research, etc.

However, a simple listing of items does not answer the question of what the standard should be for judging how much and what sort of information should be provided. One standard frequently invoked in medical practice, namely the information commonly provided by practitioners in the field or in the locale, is inadequate since research takes place precisely when a common understanding does not exist. Another standard, currently popular in malpractice law, requires the practitioner to reveal the information that reasonable persons would wish to know in order to make a decision regarding their care. This, too, seems insufficient since the research subject, being in essence a volunteer, may wish to know considerably more about risks gratuitously undertaken than do patients who deliver themselves into the hand of a clinician for needed care. It may be that a standard of "the reasonable volunteer" should be proposed: the extent and nature of information should be such that persons, knowing that the procedure is neither necessary for their care nor perhaps fully understood, can decide whether they wish to participate in the furthering of knowledge. Even when some direct benefit to them is anticipated, the subjects should understand clearly the range of risk and the voluntary nature of participation.

A special problem of consent arises where informing subjects of some pertinent aspect of the research is likely to impair the validity of the research. In many cases, it is sufficient to indicate to subjects that they are being invited to participate in research of which some features will not be revealed until the research is concluded. In all cases of research involving incomplete disclosure, such research is justified only if it is clear that (1) incomplete disclosure is truly necessary to accomplish the goals of the research, (2) there are no undisclosed risks to subjects that are more than minimal, and (3) there is an adequate plan for debriefing subjects, when appropriate, and for dissemination of research results to them. Information about risks should never be withheld for the purpose of eliciting the cooperation of subjects, and truthful answers should always be given to direct questions about the research. Care should be taken to distinguish cases in which disclosure would destroy or invalidate the research from cases in which disclosure would simply inconvenience the investigator.

Comprehension. The manner and context in which information is conveyed is as important as the information itself. For example, presenting information in a disorganized and rapid fashion, allowing too little time for consideration or curtailing opportunities for questioning, all may adversely affect a subject's ability to make an informed choice.

Because the subject's ability to understand is a function of intelligence, rationality, maturity and language, it is necessary to adapt the presentation of the information to the subject's capacities. Investigators are responsible for ascertaining that the subject has comprehended the information. While there is always an obligation to ascertain that the information about risk to subjects is complete and adequately comprehended, when the risks are more serious, that obligation increases. On occasion, it may be suitable to give some oral or written tests of comprehension.

Special provision may need to be made when comprehension is severely limited—for example, by conditions of immaturity or mental disability. Each class of subjects that one might consider as incompetent (e.g., infants and young children, mentally disabled patients, the terminally ill and the comatose) should be considered on its own terms. Even for these persons, however, respect requires giving them the opportunity to choose to the extent they are able, whether or not to participate in research. The objections of these subjects to involvement should be honored, unless the research entails providing them a therapy unavailable elsewhere. Respect for persons also requires seeking the permission of other parties in order to protect the subjects from harm. Such persons are thus respected both by acknowledging their own wishes and by the use of third parties to protect them from harm.

The third parties chosen should be those who are most likely to understand the incompetent subject's situation and to act in that person's best interest. The person authorized to act on behalf of the subject should be given an opportunity to observe the research as it proceeds in order to be able to withdraw the subject from the research, if such action appears in the subject's best interest.

Voluntariness. An agreement to participate in research constitutes a valid consent only if voluntarily given. This element of informed consent requires conditions free of coercion and undue influence. Coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance. Also, inducements that would ordinarily be acceptable may become undue influences if the subject is especially vulnerable.

Unjustifiable pressures usually occur when persons in positions of authority or commanding influence—especially where possible sanctions are involved—urge a course of action for a subject. A continuum of such influencing factors exists, however, and it is impossible to state precisely where justifiable persuasion ends and undue influence begins. But undue influence would include actions such as manipulating a person's choice through the controlling influence of a close relative and threatening to withdraw health services to which an individual would otherwise be entitled.

2. Assessment of Risks and Benefits.—The assessment of risks and benefits requires a careful arrayal of relevant data, including, in some cases, alternative ways of obtaining the benefits sought in the research. Thus, the assessment presents both an opportunity and a responsibility to gather systematic and comprehensive information about proposed research. For the investigator, it is a means to examine whether the proposed research is properly designed. For a review committee, it is a method for determining whether the risks that will be presented to subjects are justified. For prospective subjects, the assessment will assist the determination whether or not to participate.

The Nature and Scope of Risks and Benefits. The requirement that research be justified on the basis of a favorable risk/benefit assessment bears a close relation to the principle of beneficence, just as the moral requirement that informed consent be obtained is derived primarily from the principle of respect for persons.

Injustice may appear in the selection of subjects, even if individual subjects are selected fairly by investigators and treated fairly in the course of research. Thus injustice arises from social, racial, sexual and cultural biases institutionalized in society. Thus, even if individual researchers are treating their research subjects fairly, and even if IRBs are taking care to assure that subjects are selected fairly within a particular institution, unjust social patterns may nevertheless appear in the overall distribution of the burdens and benefits of research. Although individual institutions or investigators may not be able to resolve a problem that is pervasive in their social setting, they can consider tributive justice in selecting research subjects.

Some populations, especially institutionalized ones, are already burdened in many ways by their infirmities and environments. When research is proposed that involves risks and does not include a therapeutic component, other less burdened classes of persons should be called upon first to accept these risks of research, except where the research is directly related to the specific conditions of the class involved. Also, even though public funds for research may often flow in the same directions as public funds for health care, it seems unfair that populations dependent on public health care constitute a pool of preferred research subjects if more advantaged populations are likely to be the recipients of the benefits.

One special instance of injustice results from the involvement of vulnerable subjects. Certain groups, such as racial minorities, the economically disadvantaged, the very sick, and the institutionalized may continually be sought as research subjects, owing to their ready availability in settings where research is conducted. Given their dependent status and their frequently compromised capacity for free consent, they should be protected against the danger of being involved in research solely for administrative convenience, or because they are easy to manipulate as a result of their illness or socioeconomic condition.

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