Informed consent in human experimentation before the Nuremberg code

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This Nuremberg issue of the BMJ comprises seven papers in this special section, editorials by Jennifer Leaning and Donald Acheson, two personal views, four news items and three book reviews. In addition, we are publishing on pp 1448-9 the Nuremberg code from 1947 and the Declaration of Helsinki that was derived from it. All the Nuremberg material is available on the BMJ's homepage: http://www.bmj.com

The issue of ethics with respect to medical experimentation in Germany during the 1930s and 1940s was crucial at the Nuremberg trials and related trials of doctors and public health officials. Those involved in horrible crimes attempted to excuse themselves by arguing that there were no explicit rules governing medical research on human beings in Germany during the period and that research practices in Germany were not different from those in allied countries. In this context the Nuremberg code of 1947 is generally regarded as the first document to set out ethical regulations in human experimentation based on informed consent. New research, however, indicates that ethical issues of informed consent in guidelines for human experimentation were recognised as early as the nineteenth century. These guidelines shed light on the still contentious issue of when the concepts of autonomy, informed consent, and therapeutic and non-therapeutic research first emerged. This issue assumes renewed importance in the context of current attempts to assess liability and responsibility for the abuse of people in various experiments conducted since the second world war in the United States, Canada, Russia, and other nations.

Albert Neisser, 1855-1916

First Prussian directive on informed consent

The introduction of scientific and experimental methodology into clinical medicine in the nineteenth century brought with it an increased demand for experimentation on human subjects, particularly in bacteriology, immunology, and physiology. This research was done mainly on patients in hospital, often without their consent, under an "ethos of science and medical progress." As a result of injury to some patients subjected to non-therapeutic research, however, controversy and public debate ensued about the ethics of human experimentation.[1-4]

In 1891 the Prussian minister of the interior issued a directive to all prisons that tuberculin for the treatment of tuberculosis "must in no case be used against the patient's will."[5] But the first detailed regulations about non-therapeutic research in Western medicine came from the Prussian minister for religious, educational, and medical affairs in 1900. They were issued after critical public discussion and political debate on the Neisser case in the Prussian parliament and set forth the legal basis of disclosure and unmistakable consent.[1 2] Of particular interest is the debate within the medical profession and the political circumstances.

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The Neisser case

In 1898 Albert Neisser, discoverer of the gonococcus and professor of dermatology and venereology at the University of Breslau, published clinical trials on serum therapy in patients with syphilis. In order to find a method of syphilis prevention he injected cell fre
serum from patients with syphilis into patients wh
were admitted for other medical conditions. Most c
these patients were prostitutes, who were neithe
informed about the experiment nor asked for their cor
sent. When some of them contracted syphilis Neisse
concluded that the "vaccination" did not work
However, he argued that the women did not contrac
syphilis as a result of his serum injections but contracte
the disease because they worked as prostitutes. Libera
newspapers published these and other cases, triggerin
public debate.

Most academic physicians at the time supporte
Neisser. An exception was Albert Moll,[6] a psychiatrist i
private practice in Berlin, who collected in hi
Physicians' Ethics 600 cases of unethical non-therapeuti
research on humans and emphasised the need fo
informed consent. Moll also developed a legally base
positivistic contract theory of the patient-docto
relationship, which is widely ignored in current bio
ethics publications.[7]

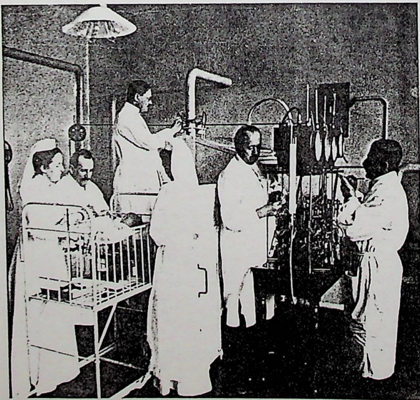
In 1898 the public prosecutor investigated the cas
and Neisser was fined by the Royal Disciplinary Cour
The court ruled that, though Neisser as a well know
medical authority may have been convinced that the tr
als were harmless, he should have sought the patient
consent. Not questionable science but lack of patient
consent was the main principle for the legal judgmen

GOVERNMENT ACTION

The Prussian parliament also discussed the case several times and in 1899 asked the government to act. As a result the minister for religious, educational, and medical affairs commissioned a detailed report from the Scientific Medical Office of Health, which was composed of leading German physicians such as Rudolf Virchow. The commission directed its attention to beneficence and autonomy. It concluded that a physician who recognised that an injected serum might cause infection had no right to inject such a serum. In any case, both informing the subject and obtaining the subject's consent were preconditions to experimentation. In a handwritten report Emil von Behring argued that, particularly with reference to the Neisser case, self experimentation should always precede experiments on patients. He personally held that purely scientific experimentation on human subjects was unethical even if they gave voluntary consent.[1-4]

The minister also sought legal advice on the Neisser case. Lawyers stated that conducting non-therapeutic research on a subject without consent fulfilled the criteria for causing physical injury in criminal law. The scientific validity of the experiment did not serve as mitigation. Informed consent was a mandatory precondition for any non-therapeutic research. Problems of coercion, persuasion, and the unequal authority between doctor and patient were discussed in detail, and the lawyers concluded that respect for rights and morality had the same importance for the good of mankind as medical and scientific progress. Written documentation and clear responsibility of the medical director for all human experimentation became legal doctrine.

Finally, in 1900 the minister for religious, educational, and medical affairs issued a directive to all hospitals and clinics. Medical directors were advised that all medical interventions other than for diagnosis, healing, and immunisation were excluded under all circumstances if "the human subject was a minor or not competent for other reasons" or if the subject had not given his or her "unambiguous consent" after a "proper explanation of the possible negative consequences" of the intervention. All research interventions could be performed only by the medical director or with his or her authorisation. In all cases fulfilment of these requirements as well as all further circumstances of the case had to be "documented in the medical history." Despite all this, however, the directive was not legally binding and little is known of its impact on human experimentation.


FREIE UNIVERSITAT BERLIN

Medical experimentation on a metabolic ward of the Kaiserin Auguste Victoria Haus, Berlin, in the 1920s

Circular of the Reich minister of the interior: guidelines for new therapy and human experimentation, 1931

Because of criticism of unethical human experimentation in the political press and in parliament as well as in the context of a political reform of criminal law in Germany, in 1931 the Reich government issued detailed "guidelines for new therapy and human experimentation." The guidelines clearly distinguished between therapeutic ("new therapy") and non-therapeutic research ("human experimentation") and set out strict precautions.

Besides the principles of beneficence and non-maleficence, the regulations were based on patient autonomy and a legal doctrine of informed consent. "New therapy may be applied only if consent or proxy consent has been given in a clear and undebatable manner following appropriate information. New therapy may be introduced without consent only if it is urgently required and cannot be postponed because of the need to save life or prevent severe damage to health. . . ." In those cases a written report must clearly outline the preconditions. But non-therapeutic research was "under no circumstances permissible without consent."[8] Written documentation and a clear structure of responsibility for each clinical trial were required. Though an early model of institutional review boards was discussed, the official guideline adopted the hierarchical model from the directive of 1900, in which the medical director was responsible for all clinical research in the institution.

As later formulated in the Nuremberg code, a careful cost-benefit calculation and a detailed research plan with animal experimentation beforehand were already required to minimise risk to human subjects. Some regulations were even stricter and more detailed than those contained in the Nuremberg code and the much later Declaration of Helsinki. Human experimentation on dying patients was absolutely prohibited. Publication of the results of new therapy must respect the patient's dignity and the mandate of humanity. In academic teaching every opportunity should be taken to emphasise the special responsibilities of a physician undertaking clinical trials. Even further, any exploitation of social or economic need in testing new therapies was rejected.

Discussion

This paper shows that explicit directives concerned with the welfare of people subjected to medical experimentation in Germany were in place long before the Nuremberg code was devised in 1947.[9-12] Critical press reports and debate in parliament forced the Prussian government to issue the first directive concerned with medical experimentation in humans in 1900. This directive was based on medical and legal scientific reports. A clear distinction was made between therapeutic and non-therapeutic research, but regulations were issued only for non-therapeutic research. The regulations were based on the principle of autonomy and represented an early model of informed consent. A "proper explanation of the possible negative consequences" of the intervention and "unambiguous consent" became the mandatory standard. In addition, legal reports carefully discussed aspects of coercion, persuasion, and imbalance of authority between patient and doctor just as in contemporary work.[13] Minors and incompetent subjects were generally excluded from non-therapeutic research, as they could not give valid informed consent.

We conclude that at the turn of the century informed consent was already a legal doctrine in medical experimentation in Germany, being based on "unambiguous consent" of the subject after "proper" information had been given by the doctor, including negative consequences and side effects. Interestingly, the regulations were not initiated by doctors or research institutions but were issued by government authorities. However, it remains an open question how informed consent was applied by doctors in research and clinical practice and how it shaped the individual doctor-patient relationship.[14-16]

The guidelines issued by the Reich government in 1931 regulated therapeutic and non-therapeutic research in human subjects. Whereas without exception non-therapeutic research could be performed only with the subject's informed consent, therapeutic research could be performed without explicit consent but only in a medical emergency and if it was deemed to be in the patient's best interest.

The second part of the Prussian directive of 1900 defined a structure of responsibility in medical institutions. Because of the hierarchical structure in German hospitals only the medical director and physicians authorised by the medical director were allowed to conduct research on human subjects. However, in no case of injury to a patient by experimentation was the issue of responsibility controversial, as all medical directors and professors declared their personal responsibility. This hierarchical model of responsibility, also found in the Reich government's guidelines of 1931, differs from the modern concept of responsibility in clinical research. Under current concepts the individual researcher is personally responsible for his or her actions and ethical issues are assessed by peers on institutional review boards.

For the first time in history informed consent, the research process, and explicit clarification of personal responsibility for the experiment were required to be included in the medical record. In addition, issues of written research plans with a risk-benefit assessment, the need for previous animal experimentation, and medical self experimentation were raised. Though a system of public health insurance existed in Germany in 1931 and provided good health care for all citizens, issues of social justice and the protection of poor people in medical research were regulated. We question whether the healthcare system in the United States would meet these regulations, many patients without health insurance having no access to regular medical treatment. In order to obtain medical help these patient must rely on free experimental treatment in research institutions without having a choice whether to give free and autonomous informed consent.

Though present conceptions of informed consent differ from those in the Prussian directive of 1900 and the Reich government's guidelines of 1931, some basic elements can be identified in postwar regulations[17 18] together with many ethical issues of human experimentation.[17-23] Our primary objective was to show that the basic concept of informed consent was developed long before the second world war and before Nazi crimes in Germany, not on the initiative of the medical profession or research community but as a legal doctrine by government authorities. The guidelines of 1931 were not annulled in Nazi Germany, when unethical experiments were performed by German doctors in concentration camps. Though no other nation seems to have had such ethically and legally advanced regulations at the time, these did not prevent crimes against humanity by part of the German medical profession.[9-12]

Key messages

- The Nuremberg code of 1947 is widely regarded as the first document providing ethical regulations in human research on the basis of informed consent
- New research has uncovered ethical issues of informed consent in human experimentation as early as the nineteenth century
- Regulations were not initiated by the medical profession but were issued after critical public discussion and political debate
- Basic elements of the modern legal concept of informed consent can be found in these early regulations
- These early regulations were not binding in the legal sense and little is known about their actual impact on clinical research

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1 Tashiro E. *Die Waage der Venus. Venerologische Versuche am Menschen zwischen Fortschritt und Moral.* Husum: Matthiesen, 1991
2 Elkeles B. Medizinische Menschenversuche gegen Ende des 19. Jahrhunderts und der Fall Neisser. Rechtfertigung und Kritik einer wissenschaftlichen Methode. *Med Hist J* 1985;20:135-48.
3 Winau R. Vom kasuistischen Behandlungsversuch zum kontrollierten klinischen Versuch. In: Helmchen H, Winau R, eds. *Versuche mit Menschen.* Berlin: de Gruyter, 1986.
4 Lederer SE. *Subjected to science. Human experimentation in America before the second world war.* Baltimore: Johns Hopkins University Press, 1995
5 Official Regulations as to Tuberculin in Germany and Italy. *JAMA* 1891;16:492. (Original German publication: *Ministerial-Blatt für die gesamte innere Verwaltung in den Königlich Preußischen Staaten* 1891;52:27.)
6 Moll A. *Ärztliche Ethik.* Stuttgart: Enke, 1902.
7 Schultz JH. *Albert Molls Ärztliche Ethik.* Zurich: Juris, 1986
8 Luther E, Thaler B. *Das hippokratische Ethos. Untersuchungen zu Ethos und Praxis in der deutchen Ärzteschaft.* Halle (Saale): Wissenschaftliche Beitrage der Martin-Luther-Universitat Halle-Wittenberg, 1967
9 Mitscherlich A, Mielke F. *Wissenschaft ohne Menschlichkeit. Medizinische und eugenische Irrwege unter Diktatur, Bürokratie und Krieg.* Heidelberg: Lambert Schneider, 1949. (English translation: *Doctors of infamy. The story of the Nazi medical crimes.* New York: Schuman, 1949.)
10 Müller-Hill B. *Tödliche Wissenschaft. Die Aussonderung von Juden, Zigeunern und Geisteskranken 1933-1945.* Reinbeck bei Hamburg: Rowohlt, 1984
11 Kater MH. *Doctors under Hitler.* Chapel Hill: University of North Carolina Press, 1989.
12 Caplan AL (ed). *When medicine went mad. Bioethics and the Holocaust.* Totowa: Humana Press, 1991.
13 Faden RR, Beauchamp TL. *A history and theory of informed consent.* New York: Oxford University Press, 1986.
14 Katz J. *The silent world of doctor and patient.* New York: Free Press, 1984.
15 Pernick MS. *The patient's role in medical decisionmaking: a social history of informed consent in medical therapy.* In: President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, ed. *Making health care decisions.* Vol 3. Washington, DC: US Government Printing Office, 1991.
16 Vollmann J. *Das Informed Consent-Modell als Politikum in der Medizin. Patientenaufklärung und Einwilligung aus historischer und medizinethischer Perspektive.* Frankfurt am Main: Suhrkamp (in press).
17 Annas GJ. The changing landscape of human experimentation: Nuremberg, Helsinki and beyond. *Health Matrix J Law Med* 1992;2:119-40.
18 Sass HM. Reichsrundschreiben 1931: pre-Nuremberg German regulations concerning new therapy and human experimentation. *J Med Philos* 1983;8:99-111.
19 Beecher HK. Ethics and clinical research. *N Engl J Med* 1966;274:1354-60.
20 Katz J. *Experimentation with human beings: the authority of the investigator, subject, professions and the state in the human experimentation process.* New York: Russell Sage Foundation, 1972.
21 Jones JH. *Bad blood: the Tuskegee syphilis experiment.* New York: Free Press, 1981.
22 Advisory Committee on Human Radiation Experiments. *Final report.* Washington, DC: Government Printing Office, 1995.
23 Smith R. Time to face up to research misconduct. *BMJ* 1996;312:789-90.

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The Nuremberg Code (1947)

The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects.

PERMISSIBLE MEDICAL EXPERIMENTS

The great weight of the evidence before us to effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Taken from Mitscherlich A, Mielke F. *Doctors of infamy: the story of the Nazi medical crimes*. New York: Schuman, 1949: xxiii-xxv.

Declaration of Helsinki (1964)

Recommendations guiding physicians in biomedical research involving human subjects

Adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964, amended by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and the 35th World Medical Assembly, Venice, Italy, October 1983

INTRODUCTION

It is the mission of the physician to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient."

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies especially to biomedical research.

Medical 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 recognised between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research the essential object of which is purely scientific and without implying direct diagnostic or therapeutic value to the person subjected to the research.

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

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to every physician in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Physicians are not relieved from criminal, civil and ethical responsibilities under the law of their own countries.

I. BASIC PRINCIPLES

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7. Physicians should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Physicians should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the physician is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The physician should then obtain the subject's freely given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the physician should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a physician who is not engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation. Whenever the minor child is in fact able to give a consent, the minor's consent must be obtained in addition to the consent of the minor's legal guardian.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present declaration are complied with.

II. MEDICAL RESEARCH COMBINED WITH PROFESSIONAL CARE (CLINICAL RESEARCH)

1. In the treatment of the sick person, the physician must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, re-establishing health or alleviating suffering.

2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3. In any medical study, every patient—including those of a control group, if any—should be assured of the best proven diagnostic and therapeutic method.

4. The refusal of the patient to participate in a study must never interfere with the physician-patient relationship.

5. If the physician considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee (1, 2).

6. The physician can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. NON-THERAPEUTIC BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (NON-CLINICAL BIOMEDICAL RESEARCH)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the physician to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2. The subjects should be volunteers—either healthy persons or patients for whom the experimental design is not related to the patient's illness.

3. The investigator or the investigating team should discontinue the research if in his/her or their judgment it may, if continued, be harmful to the individual.

4. In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject.

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INTERNATIONAL CONFERENCE
HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Ethics and Human Values in Medical Education

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In India little attention has so far been paid to the teaching of "code of ethics and human values" to the medical students during their periods of undergraduate and postgraduate medical education. However it has been realised that the well trained doctors should be able to meet the health and allied needs of the community by fulfiling their obligations and duties towards them. Bhatnagar et al. (1977) have discussed the competencies in terms of skills, knowledge and attitudes, which the student may have to learn preferably in a family/community environment, particularly in the rural areas, for becoming a doctor who, in future, is likely to go in for family medicine/general practice. Such need based rural oriented training must include the managerial and supervisory skills, basic principles of research i.e. collection, recording and interpretation of data, and capability to deliver the comprehensive health care including the preventive, promotive, curetive, disability—limiting and rehabilitative services, Dr. P.C. Bhatla, Dean IMA College of General Practitioners, India, (1983) has drawn a training grogramme including ethical, moral and social aspects of Family Medicine/General Practice, for postgraduates in these subjects.

While evolving the National Health policies an attempt has been made to provide comprehensive health care to ALL, atleast at the Primary level. Cases needing routine specialist care can be referred to Secondary or Intermediate Health Care organisations based in or about the district.

Only few selected cases meriting the attention of super-specialists for Advanced Medical Techology should alone be referred to the tertiary health care level institutions located in teaching hospitals and Institutes of National importance. However this system is failing due to our defective Referral services, which are not optimal and criteria-oriented and because in the opinion of most, in developing countries like India primary health care to ALL should still be given preference over the costly life-saving demands for few (Bhatnagar et. al., (1982).

The code of Ethics and human values helps guide the National Health Policy Planners, to examine the priorities and moral validity of choices available to them. They have to take decisions in terms of Equity, social Justice, care for all, value of human dignity and life, sociocultural and religious traditions and moral validity, within the constraints of availability of Men, Material, Money, Equipment and other resources.

The code of Ethics and human values commit the medical practitioners to certain social values above the selfish ones e.g, of income, power, and prestige etc. Medical ethics also dedicates the Doctor to the HIGHER VALUES OF SAVING OF LIVES and the PROTECTION OF PATIENTS HEALTH—ABOVE ALL MATERIAL AND PERSONAL CONSIDERATION (RALPH W. TYLER-1952).

[A list of ethical and human values to be learnt by a doctor is given at the end of this presentation as an appendix.]

It must be realised that moral attitudes and human values are never inborn. They have always to be learnt consciously in programmes of not only medical education but also from the education involved in socio-cultural, political and religious activities, Mostly they are developed from observations and opinions expressed by their seniors, but they can be consciously developed by motivating the individual to think, feel, actively participate and often derive satisfaction from a real-life or simulated situation; thereby developing a relevant desired learning behavioural pattern/opinion. An occasional feedback from the teacher will facilitate the development of such a learning.

As these moral attitudes and human values are LINKED WITH EMOTION, they are relatively vague, impressionistic, and ill-defined and therefore DIFFICULT TO MEASURE. Yet, some measurement is better than no measurement, and therefore, changes in behaviours and opinions are gainfully used to infer the development of a change in attitude (Razler 1973; Bhatnagar 1983)

Before I close, I take this opportunity to thank the organisers of this International conference on Ethics and human values, for inviting me to participate and thereby allow me to contribute and to learn from its proceedings. I hope the free and frank discussions during these deliberations will be sincerely followed and the results will be fruitful to all.

APPENDIX

List of Ethical and Human Values to be Learnt by a Doctor

The doctor should be able to develop :—

1. Healthy patient-doctor relationship, with ability to advocate the patients cause.

2. Healthy doctor-doctor and doctor-paramedical relationship.

3. Intrinsic goodness, kindness, understanding, compassion, patience, politeness, courtesy, helpfulness, trust, personalised attention, good bedside manners, and moral character.

4. Excellence in his work, ability to provide advice about genetic and marriage counselling, health legislation, medicolegal procedures and family problems after death.

5. realisation of limitations for referrals.

6. Respect for national and cultural traditions and for other systems of medicine.

7. Ability to rehabilitate vulnerable, handicapped and terminally ill patients.

Note : Such a list can never be complete, all are welcome to and. ☐

References

1. Agnes, G. Rezler (1973), The assessment of attitudes, W.H.O. (1973) Public Health Papers, 52.

2. Bhatla, P.C. (1983), Residency Training in General Practice, Family Medicine—A Plan.

3. Bhatnagar, O.P. et.al. (1977), Health needs of the community—conclusions of a workshop on medical education. Ind. Jour. Med. Ed. (1977), 16, 1-5.

4. Bhatnagar, O.P. et.al. (1977), Duties and obligations of a basic doctor in relation to health needs of the community. Ind. Jour. Med. Ed. (1977), 16, 1-9.

5. Bhatnagar, O.P. et.al. (1977), Suggesting improvements in the curriculum for the teaching of Physiology and Biochemistry in the fulfilment of the duties and obligations of a basic doctor towards the community—conclusions of a workshop on medical education. Ind. Jour. Med. Ed. (1977), 16, 1-22.

6. Bhatnagar, O.P. et.al (1982), Educational consequences of comprehensive health care—curriculum development tertiary level.
Ind. Jour. Med. (1982), 21, 1-8.

7. Bhatnagar, O.P. (1983), Evaluation techniques for assessing the role of social and behavioural sciences in catalysing population change. Ind. Jour. Med. Ed. (1983), 22, 92-94.

8. Bryant, John. H. and Bankowski Zbigniew (1984), Health policy : Ethics and Human Values—An international dialogue—Highlights of XVIII CIOMS Conference—Athens 1984).

9. Ralph W. Tyler (1952), Distinctive attributes of education for the professions. Social work journal of the American Association of Schools of Social Work—(April 1952).

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1980

New Trends in Medical Education Technology Particularly in Relation to Physiology Teaching

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Introduction

Medical Education has been a source of concern for many years to those involved in the training of health personnel. Changes in socio-economic conditions in all parts of the world and more so in India have been deeply influencing the health status as well as the health needs and demands of the population but hardly any account has been taken to these changes and the training of health personnel is still the traditional one as utilised in the past. It seems reasonable to believe that an educational programme has more chance of being effective if its goals have been clearly expressed. Experimental research in this connection indicates that it is not possible to measure the results obtained from an educational system if its objectives have not been explicitly defined (Guilbert 1976).

What is required, is to make sure that educational programmes are made relevant to the health needs of the community. Educational objectives must be generated on the basis of data obtained from multiple sources e.g. Health needs, demands and resources of the society, services to the patients and to the community, production of health personnel e.g. practising doctors, teachers and research workers.

After this all the departments in a medical college should develop the departmental objectives on the basis of which staff members who are assigned teaching would develop specific intructional objectives. A recent study suggest that the systematic attempt to write INSTRUCTIONAL/ learning objectives leads to clarification of an instructors goal and provides the basis for dialogue with colleagues which in turn may lead to further refinement of one's objectives. Clear understanding of objectives leads to better decisions in the teaching and evaluation process (William etal, 1982).

Educational Technology

Teaching has been defined as a process of helping learners to learn. As such, it is not merely an art to which one is born but a *science* that should be learnt by all future teachers. It is increasingly recognised that being, for example, a good researcher is no guarantee of being a good teacher. Awareness is growing that teaching skills are far too important and there is a need for systematic, conscious preparation of teachers for their professional tasks (Fulop, 1978).

Most teachers training courses focus attention on the model of competency based curriculum. Learning objectives are derived from competencies that a student should acquire. Content and Teaching methods in turn are dependent upon the learning objectives and evaluation of students performance (Mc Gahie etal, 1978).

Physiology teaching

Methods of teaching physiology fall into the traditional categories of lectures, tutorials, practicals and demonstration classes. The other methods are Seminar, Symposium or Group discussions. Some methods recently introduced are problem based learning; programmed learning or competency based learning and teaching physiology in the Hospital set up to make it clinically oriented right from the Ist year curriculum.

Lectures

It is a careful presentation of facts with organised thoughts and ideas by a qualified person. Lectures continue to be the corner stone of medical education and efforts should be made to make them more interesting by the use of audio-visual aids. Moreover, if a students 700 to 1000 lectures in their preclinical years than a legitimate concern of Medical educators should be to make lectures efficient for recording by students (Brown 1980).

The advantages of lecture are that they provide upto date and large amount of material in short time, covers a large group of students and there is an apparent saving of time and resources.

The major disadvantage is that it keeps the student in passive situation, has low receptivity and offers hardly any opportunity of checking learning process.

Practicals

Practical play an important role in educational technology because they help in introducing, developing and reinforcing theoretical concepts taught in lectures. Traditional Amphibian experiments should be curtailed to a minimum and more emphasis should be laid on Human Physiology and Interpretation of graphs and problem solving exercises. These test the capacity of a student to give a precise, to the point expression of his thoughts and one exclusive advantage of this system is that its questions could be framed at leisure by the participation of Faculty in such a way as to incorporate the type of knowledge it is desired to be inculcated by the student.

Tutorials

Is a small group activity. These could be usefully utilised by identifying students with poor scoring and helping them to take part in discussion. It has distinct advantage of permitting teacher student dialogue facilitating self evaluation and development of confidence.

Seminar

It is an activity in which group of persons engaged in research or advanced study meet under the general direction of one or more staff members for discussion on problems of mutual interest. These are not utilised in a routine manner for undergraduate teaching. However, every department arranges a few seminars for the benefit of students. These are helpful in giving an opportunity to students (all members) to participate in discussion and to study a subject in depth under an authority. Disadvantage is constraint of time available to students for preparation of reports.

New trends—programmed learning

In this instructional workbooks are programmed to help students to attain a specified level of performance. This is a innovation which has been tried in certain universities abroad. In this the student uses a synchronised slide tape equipment or a video tape at his leisure time. This also enables the student to work at his own pace, facilitates self evaluation and has been found to be every effective (Alexander etal 1980).

Problem based learning projects into a clinical corelation

This could be introduced in the Ist year curriculum. An important objective of this project is to show students how their studies in preclinical courses could help them with the analysis and solution of a clinical problem. Another aim is to develop student participation in team work. With this method most students were encouraged to develop their won initiative and to practice logical sequence of thought required to solve problems. (Lambie et al 1981). This also helps in interdisciplinary teachings.

Problem based Learning

Learning from problems is regarded as a condition of human experience. Learning occurs naturally in attempts to face the problems encountered by every person each day—Problem based learning is ideally suited for student centered and individualised learning. Learning resources include tape slide programme, video-tapes, audio-tapes, films.

Instructional-media

Role of Audio-visual media in Physiology Teaching. Besides the role of chalk and Board, overhead and slide projector models and charts, and interesting recent development has been the application of programmed audio-visual material for teaching purposes in the class rooms. However, many faculties of medicine in Europe and USA are experimenting with different approaches to this method of teaching, in which the student can proceed at his own pace and which includes various devices to include active student participation.

In some faculties these studies are carried out in separate booths or carrels; in others the material with simple battery operated equipment are taken away by students and worker away from faculty premises; in yet other students in groups of three or four work together on the programmes. The material produced varies from a taped lecture with slides to a programmed course with defined objectives, which is modified after a trial with successive student groups until it reaches a predetermined level of efficacy. Although in most faculties, this system is a innovation and therefore, difficult to assess in comparison with conventional teaching practice. However, at the Faculty of Rotterdam Netherlands whole course of a year has been transferred on to audiotapes with slides and the faculty had now 3 years experience of this method and found it successful.

In conclusion, there is no doubt that recent educational technology is an exciting field of development in Medical teaching, if we accept, that student learning is a major goal of teaching institutes, then we cannot afford to ignore the most powerful of the senses, the visual channels.

Coloured video tapes

These are very good for self instructional learning or small group learning. Easy to operate with casettes. Could be used repeatedly. Useful for programmed instructions/or demonstration of Experiments.

Closed circuit T.V. system

Useful for small and large groups and class rooms. Very efficient in transmitting an action where only limited persons can participate. Using a VCR it is possible to record picture or action of an experimental technique/demonstration and play back for giving revision to those students who could not follow initially. The limitations are that CC TV is very costly. Special technical staff is required. Useful for self instruction by video-tapes.

Evaluation

Out-moded methods of evaluation still in use provide only some information on the students capacity for memorization but do not assess the individual's ability to cope with real problems faced after graduation (Fulop 1978). Evaluation is a systematic process of determining the extent to which the pre-determined objectives are achieved. It includes qualitative measurement of a student behaviour plus judgements concerning the desirability of that behaviour. It plays an important role in education. Helps in selection of students, monitoring of learning process, giving feed back to students. Determining success or failure of students; and determining programme effectiveness.

Types of evaluation procedures

(1) Formative (Daignostic) – These are to defect specific strength and weakness of individual students.

(2) Summative (Certifying)—To determine the overall achievement of a satisfactory level of competence, usually at the time of graduation.

Methods of evaluation

The conventional old method was to have a written test having essay types of questions but now it is felt that a mixture of specific essay type and short structured questions are more meaningful. Multiple choice questions (MCQ) arc very good because they are objective and there is no element of subjective assessment. Practicals assessment comprises of a laboratory exercise coupled with some problem solving exercises or interpretation of graphs. Along with this there is a oral examination as well in practically all the medical colleges.

Internal assessment

Continuous assessment of the students throughout the terms forms the basis of giving internal assessment marks. A percentage is determined and recorded. This type of assessment has the advantage of being based on observing the student actually at work throughout their stay in the department. This type of evaluation is not only fair, but also provides a feed back to the student and teacher for further improvement. However, for certification and assessment is also important. These two types of assessment may carry equal weightage.

Some innovations recommended

(1) PROBLEM BASED LEARNING PROJECTS INTO A CLINICAL CORELATION IN FIRST YEAR

We would like to emphasize that teaching of physiology should be clinically oriented as far as possible to make it meaningful and purposeful for the basic doctors. In view of this exposure of students to health clinics in OPDS and problem based learning projects into a clinical corelation course could be introduced in the Ist year curriculum and even during lectures emphasis should be laid on impressing upon the students as to how this basic-knowledge of physiology is going to be of value on clinical side.

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References

1. Alexander, D.A. & Haldane, J.D. (1980) Medical Education, the discontinous view point. Medical Education, 14, 16-22.

2. Brown, G. (1980) Learning from lectures in medicine, University of Nottingham.

3. Dowling, M.A.C. (1972) W.H.O. chronicle, 26(1), 3-6.

4. Fulop, T. (1978) W.H.O. Chronicle, 33(8) : 303-306.

5. Guilbert, J.J. (1976) Educational handbook. W.H.O. communication.

6. Lambie, A,T. Una Maclean C.M. and Mc. Guive R.J. (1981). The introduction of problem based learning projects into a clinical corelation course in the first year of the edinburgh medical curriculum. Medical Education, 15,209-215.

7. Mc. Gaghie, W.C. Miller, G.E., Sajid, A.W. and Telder, T.V. (1978) Competency based curriculum development in medical education and introduction public Health paper No. 68, World Health Organisation, Geneva.

8. Williams, R.C. and Osborne C.E. (1982) Medical Education, 16 68-71.

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A Look at Rural Surgery in Private Sector in India

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80% population in India is residing in Rural Areas, besides solving the Health and Medical problems of this population, we need to cater for their Surgical needs also. This is done by Government Sector through Primary Health Centres, and Cottage Hospitals but quite a substantial Surgical work is being done by Private Rural Surgeons.

Let us see the role of these private Surgeons in delivering surgical care in rural areas, the type of surgical practice in villages and the problems and difficulties faced by the Rural Surgeons.

This paper is based on a Study conducted in an Backward Adivasi District of Dhule in the State of Maharashtra and analysis of 5769 total Surgical operations done by the author during 18 years of his work in a small private Rural Hospital in the town of Dondaicha which is not even a Taluka place.

From the Statistical Study of the District it was found out that in 1984 total 11724 operations were done in Government Sector out of which only 3362 were done at peripheral hospitals. In private sector 11652 were done out of which 2924 were done in Rural Hospitals.

If we compare the individual work done by private General Surgeons in Dhule City proper with that done by peripheral Private Surgeons it could be seem that the City Surgeon is doing on an average two hundred operations per year, while a Peripheral Surgeon is doing more than four hundred operations per year, double the work than his colleague in City.

This is partly because the rural public is getting surgical facilities at their door steps as can be seen from the map which shows that the Government Civil Hospital which undertakes major surgical work is placed at one corner of the District almost 130 Kms. away from the farthest point to reach this hospital for free treatment, the patient who is usually poor, has to first travel by a bullock cart or a hand cart or some times in hilly areas on hands or bamboos to reach the nearest bus station and then to spend about Rs. 120/- as fare for himself and his accompanying persons, at least 2-3 relatives, and almost 2 days having a night halt somewhere, instead he prefers to pay the nearby peripheral Private Surgeon. That is why there is lot of work to do for a Private Rural Surgeon.

But the nature of Rural Surgical Practice is entirely different as compared to city practice. The patients do not differentiate between a Physician, a Surgeon or a Gynaecologist so there is more work of consultation taking major part of the Surgeons time 9 A.M. to 5 P.M. In 18 years practice there were *75060* O.P.D. patients as compared to only *5769* operations.

Emergencies are much more common in comparison to city practice and disturb the sleep of the Surgeon almost daily.

As there are no assistants, Registrars or house-surgeons to work under him even after 18 years of practice, he has to carry out minor procedures like circumcisions, suturing CLWS, opening abscesses and what not.

He has to maintain his own Nursing home for which he has to first find out a building. There are no good buildings and the hospital may have to be set up in any old building built in kachha mud, but the building can be modified and decorated at least internally using asbestos sheets or plywood to form false roof and false walls.

As there are no Pathologist the Surgeon has to keep his own Laboratory and blood Transfusion Service, and a small X-ray machine on which no special investigations are possible.

There are no facilities for frozen section biopsies.

In abscence of special investigations, clinical judgment is the most important armamentarium in diagnosis.

Coming to the operation theatre equipment, usually the rural private surgeon is coming from a poor or middle class family and cannot afford to have sophisticated equipment at least in the beginning of his career, even then he has to keep enough stock of all the materials as neither he can purchase them immediately nor can he borrow from anybody.

Maintenance of costly equipment is a problem and the Surgeon himself has to repair his own equipment using gadgets like multimeters, with the help of local technicians.

Electric supply failure is a very common event and a stand by arrangement for emergency lighting and foot operated suction machine have to be kept ready and if possible a generator set installed.

Hard water can ruin the electrical heating appliances and instruments. Ion Exchange water softners can solve the problem.

Oxygen refilling takes months to get the cylinders refilled. Industrial Oxygen available locally for welding purposes can be used safely.

Anaesthesia is a big problem. Qualified anaesthetists are not available and either wife if medico or some other local doctor has to be trained for anaesthesia or some times the Surgeon himself has to induce anaesthesia and maintain the patient on Ether bottle. In abscence of Oxygen supply the only apparatus available is on Oxford of Bellow and some kind of Ether vaporisor.

With all these the Surgeon is now ready for operation, but he has no qualified staff and nurses, the hospital staff usually consists of his wife, who should preferably be a medico, and 3-4 unqualified staff trained in the same hospital.

On the operation table the Rural Surgeon has to handle Surgical problems from any system and speciality of surgical field. The analytical data of surgical procedures carried out by author in 18 years shows that out of 5769 operations 306 were on head and Neck, 601 were of ENT, 1088 of Gastro-Intestinal tract, 534 Urological Procedures, 1423 Orthopaedic Procedure, 1585 Gynace Procedures and 302 miscellaneous operations.

Thus it can be seen that the Rural Surgeon not only has to undertake general surgical work but also orthopaedic work reducing fractures, ENT Work knocking out tonsils, gynaec work doing D & Cs and hysterectomies and obstetric work conducting difficult deliveries. In fact these three specialities form almost 65% of his surgical practice.

But usually he is qualified as a General Surgeon and has no experience of doing these operations and at least in the beginning of his career to perform any new operations is a night-mare for him.

As a Surgical Registrar the author has removed only one sided tonsil that too unofficially begging the favour of E.N.T. Registrar and had to run away leaving the operation half way as the E.N.T. boss came in.

The General Surgeon's knowledge of gynaec and obstetric operations is probably limited to whatever he has seen as under graduate sitting in the operation theatre gallery, but in his practice the Rural Surgeon not only has to do Caesarean Section but even he has to use the so called obsolete methods like craniotomy and evisceration which he has never seen in his student life.

Besides surgery the Rural Surgeon has to admit all cases needing hospitalisation like unconscious patients, patients with high fevers, convulsions, status asthmaticus, heart attacks and some times even schizophrenics. So it is urged that a Rural Surgeon should be specially trained. It is suggested that after getting basic post – graduate qualification in General Surgery, the surgeon, if wants to settle in rural areas he should be allowed to do house-posts for 6 months in Gynaecology and Orthopaedics and short posts in ENT and anaesthesia. In his basic training more stress should be given to clinical methods of diagnosis and he should be taught to handle equipments like X-ray machines and preliminary knowledge of bio-engineering and repairs and maintenance of these equipments, should also be given to him. Simpler but useful procedures, may be obsolete, in fields like anaesthesia and obstetrics should be specially taught to him to make him jack of all but Master of Surgery.

Besides all these technical and clinical Problems the Rural Surgeon has to face some social and personal problems, as already said his wife should be a medico not only because she will help him in his practice tremendously, but will not get bored in village life with no facilities for entertainment—not even good people to talk with. Children education is the biggest problem. The Surgeon has no academic life and cannot do any research, but on the whole the life is calm and quiet, people respect him all over and in due course of time he earns enough to have a good livelihood and is probably happier than in his colleagues in big cities.

That is why now more and more surgeons are coming to villages and settling at peripheral places as can be seen from the map thus delivering surgical care at the door steps of village people. So also more and more Government agencies like Primary Health Centres and Cottage Hospitals are recently being set up improving the medical facilities in rural areas. That is why now it is rare to see gangrenous hands due to tight plaster unreduced dislocations with nerve palsies, patients with huge hernia, and advance breast lesions, intestinal perforations with shock, bladder stones with recto-vesical fistulae, huge ovarian cysts occupying all the abdominal cavity sometimes with bleeding gynaec problems brought in almost exsanguinated state and ruptured uteruses due to obstructed labour, a seen commonly encountered by the author in the Seventies.

Blind faith is also disappearing fast and now it is rare to see a moribund child with branding marks all over abdomen, holy ash applied to this fore head and a sacred thread tied to his wrist. Even Adivasies now bring their young-ones not only for emergencies but also for routine Surgical treatment.

Even then a lot needs to be done to achieve the goal of 'Health for all by 2000 AD" especially in rural areas. Government agencies alone may not be able to fulfil this goal. The private surgeons have a big role to play in the coming future in achieving this target, therefore it is urged that more and younger surgeons should come forward and settle in villages thus serving the masses and helping the nation and the mankind as a whole. ☐

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Under-Development and Poverty

Dr. Mrs. Lalita Rao

Under-development and poverty are corelated, in as much as the the former is the cause of the latter and vice-versa. Curiously enough 'Health' occupies a place of prominance in the phenomenon of underdevelopment. Because of the poverty, the people of a country have poor health status and they cannot effectively contribute in the process of development of the country. Development means augmenting the goods and services of a country of which there are acute shortages. In the process of development, many problems like housing, sanitation, energy, environment, food production have to be effectively solved. The advanced countries easily solved these problems and taking advantage of the industrial revolution achieved faster progress. For these countries population growth did not pose any problem as did India. Development and prosperity worked as contraceptives in these advanced countries.

The constitution of India, therefore envisaged establishing in new social order based on equality, freedom, justice and the dignity of the individual. It aims at elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunity to develop in a healthy manner. We, therefore, embarked on economic planning through the implementation of Five Year Plans. The successive Five Year Plans have been providing the framework within which the States may develop their health service infrastructure, facilities for medical education and so on. During the last three decades and more, considerable progress has been achieved in the promotion of the health status of our people. Small pox, which used to take heavy toll, has been eliminated and plague, is no longer a problem, mortality from cholera and related diseases has decreased. The mortality rate per thousand of population has been reduced from 27.4 to 14.8 and the life expectancy at birth has increased from 32.7 to over 52, according to official statistics.

In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of the people and the quality of their life. India is committed to the goal of "Health for All by the year 2000 AD" through universal provision of comprehensive primary health care services. For this purpose large inputs are necessary in the health sector and efforts are being geared up to secure the complete integration of all plans for health and human development with over-all national socio-economic development process, specially in the more closely related subjects to health, like drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water and supply and sanitation, prevention of food adulteration and conservation of the environment.

India's long-term goals are:— Improved standards of living and a stable and healthy population. The immediate goals are to reduce poverty and fertility which are inter-dependent. Therefore, India accords highest priority to the task of reducing poverty through various programmes. Improvement in the quality of life of the poor and the weaker sections of the community are the key elements of the country's development programmes and policies. The poorest 40 per cent in India are receiving a gradual but increasing share of total national income and concentration of income is declining.

Ever since independence, poverty reduction has been a fundamental goal of Indian economic and social policy. The sixth Five Year Plan estimated that in 1979-80, around 50 per cent of the entire population or nearly 340 million people, lived below poverty line, modestly defined as monthly per capita expenditure of Rs. 76 in rural, and Rs. 88 in urban areas, according to Government of India statistics. This gives us an idea of the magnitude of the task of poverty elimination, which is sought to be tackled by such national programmes as, the Minimum Needs Programme, National Rural Employment Programme, subsidising irrigation and rural electricity, rates, Education and health are two areas which are important not only from the point of view of investment in human resource development but it is the first step towards providing some equality of opportunity to the newborns by seeking to equip them with good health and at least elementary education. Achievements in these two areas are also crucial from the point of view of changes in the status of women, which have significant implications in terms of demographic change, especially fertility reduction.

It is imperative that the active co-operation and involvement of the people in the various programmes being undertaken by the government to tackle underdevelopment and eliminate poverty, is ensured, so as to have speedy results. □

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Role of Religions for World Peace : A Baha'I Perspective

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One of the objectives of this international conference is to identify and compare the ethical content of selected health policy issues from the perspectives of different religious settings. The hazards of nuclear war has become a contemporary health policy issue and many prominent physicians in the world have worked hard to raise awareness of its importance on the part of fellow physicians and the public at large. The peoples of the world increasingly recognize that the release of the destructive power of nuclear weapons would result in morbidity and mortality of a magnitude never before imagined. It has been stated that prevention of war, and nuclear war in particular, could be therefore equated with one of the most, important public health interventions of our time. The Baha'i Community is always pleased to participate in conferences organized to examine the role of religions in health policy and to provide Baha'i perspective.

The topic of the role of religions for world peace is a fundamental challenge in the world today and cuts across the professional, cultural and religious levels being discussed in this conference. I would like to take this opportunity to explore the concept of the world peace, to emphasize the role of religions in this process, to enumerate the barriers yet remaining, and to provide a vision to the remaining steps that must be taken to achieve a lasting world peace. I will draw from the recently released message from the World Centre of the Baha'i Faith to the peoples of the world entitled the Promise of World Peace. This message and topic is very timely since the United Nations has also declared that this year is the International Year of Peace.

The Great Peace towards which people of good will throughout the centuries have inclined their hearts, of which seers and poets for countless generations have expressed their vision, and for which from age to age the sacred scriptures of mankind have constantly held the promise, Baha'is feel is now at long last within the reach of the nations. The writings of the Baha'i Faith state that world peace is not only possible but inevitable.

However, we have a choice. Whether peace is to be reached only after unimaginable horrors precipitated by humanity's stubborn clinging to old patterns behaviour, or is to be embraced now by an act of consultative will, is the choice before all who inhabit the earth.

Baha'u'llah, the Prophet-Founder of the Baha'i Faith, wrote over one hundred years ago that "the winds of despair are, alas, blowing from every direction, and the strife that divides and afflicts the human race is daily increasing. The sign of impending convulsions and chaos can now be discerned, inasmuch as the prevailing order appears to be lamentable defective." Flaws in the prevailing order are conspicious in the inability of sovereign states organized as United Nations to exercise the spectre of war, the threatened collapse of the international economic order, the spread of anarchy and terrorism, and the intense suffering which these and other afflictions are causing to increasing millions.

The Baha'i Faith regards the current world confusion and calamitous condition to human affairs as a natural phase in an organic process leading ultimately and irresistibly to the unification of the human race in a single social order whose boundaries are those of the planet. The human race, as a distinct, organic unit, has passed through evolutionary stages analogous to the stages of infancy and childhood in the lives of its individual members, and is now in the culminating period of its turbulent adolescence approaching its long-awaited coming of age. Whatever suffering and turmoil the years immediately ahead may hold, however dark the immediate circumstances, the Baha'i community believes that humanity can confront this supreme trial with confidence in its ultimate outcome.

No serious attempt to achieve world peace, however, can ignore the role of religion. Baha'u'llah has said that "religion is the greatest of all means for the establishment of order in the world and for the peaceful contentment of all that dwell therein." An analogy that I particularly like is that given to us by Arnold Toynbee in this great work on the Study of History. He states that we can consider religions as the spokes on the wheel of the chariot of civilization. As the religions come into the world the wheel moves forward and is the cause of the advancement of civilizations.

Recognition of the oneness of all religions is a fundamental teaching of the Baha'i Faith. Baha' is consider that all religions are like chapters in one book—each chapter dependent and interrelated on the others—and that the Baha'i Faith, the most recent chapter, is for the purpose of creating world unity. Baha' is believe that the divisiveness and strife between religious communities is man made. Far from a fair-minded examination of the actual utterances of the Founders of the great religions, and of the social milieus in which they were obliged to carry out their missions, there is nothing to support the contentions and prejudices deranging the religious communities of mankind and therefore all human affairs. The teaching that we should all treat others as we ourselves would wish to be treated, an ethic variously repeated in all the great religions, lends force to this observation.

Banning nuclear weapons, prohibiting the use of poison gases, or outlawing germ warfare will not remove the root causes of war. However important such practical measures obviously are as elements of the peace process, they are in themselves too superficial to exert enduring influence. Peoples are ingenious enough to invent yet other forms of warfare, and to use food, raw materials, finance, industrial power, ideology, and terrorism to subvert one another in an endless quest for supremacy and dominion. Therefore a genuine universal framework must be adopted. Some of the barriers to world peace and the role that religions must play to develop this universal framework are as follows:

1. Racism, one of the most beneful and persistent evils, is a major

barrier to peace. Recognition of the oneness of mankind, implemented by appropriate legal measures, must be universally upheld if this problem is to be overcome.

2. The inordinate disparity between rich and poor, a source of acute suffering, keeps the world in a state of instability, virtually on the brink of war. The solution calls for the combined application of spiritual, moral and practical approaches.

3. Unbridled nationalism, as distinguished from a sane and legitimate patriotism, must give way to a wider loyality, to the love of humanity as a whole. Baha'u'llah has said that "the earth is but one country, and mankind its citizens."

4. Religious strife, throughout history, has been the cause of innumerable wars and conflicts, a major plight to progress, and is increasingly abhorent to the people of all faiths and no faith. The challenge facing the religious leaders of mankind is to contemplate, with hearts filled with the spirit of compassion and a desire for truth, the plight of humanity, and to ask themselves whether they cannot, in humility before their Almighty Creator, submerge their theological differences in a great spirit of mutual for bearance that will enable them to work together for the advancement of human understanding and peace.

5. The emancipation of women, the achievement of full equality between the sexes, is one of the most important, though less acknowledged prerequisites of peace. Only as women are welcomed into full partnership in all fields of human endeavour will the moral and psychological climate be created in which international peace can emerge.

6. The cause of universal education deserve the utmost support. No nation can achieve success unless education is accorded all its citizens. Consideration should also be given to teaching the concept of world citizenship as part of the standard education of every child.

7. A fundamental lack of communication between peoples seriously undermines efforts towards world peace. Adopting an international auxiliary language would go far to resolving this problem and necessitates the most urgent attention.

Two points bear emphasizing in all these issues. One is that the abolition of war is not simply a matter of signing treaties and protocols; it is a complex task requiring a new level of commitment to resolving issues not customarily associated with the pursuit of peace. The other point is that the primary challenge in dealing with issues of peace is to raise the context to the level of principle. There are spiritual principles, or what some call human values, by which solutions can be found for every social problem.

The primary question to be resolved is how the present world, with its entrenched pattern of conflict, can change to a world in which harmony and co-operation will prevail. World order can be founded only on an unshakeable consciousness of the oneness of mankind. Acceptance of the oneness of mankind is the first fundamental prerequisite for reorganization and administration of the world as one country, the home of mankind. In the Baha'i view, recognition of the oneness of mankind "calls for no less than the resconstruction and the demilitarization of the whole civilized world—a world organically unified in all the essential aspects of its life, its political machinery, its spiritual aspiration, its trade and finance, its script and language, and yet infinite in the diversity of the national characteristics of its federated units."

This principle "does not ignore, nor does it may attempt to suppress, the diversity of ethical origins, of climate, of history, of languages and tradition, of thought and habit, that differentiate the peoples and nations of the world. It calls for a wider loyality, for a longer aspiration than any that has animated the human race. It insists upon the subordination of national impulses and interests to the imperative claims of a unified world. It repudiates excessive centralisation on one hand, and disclaims all attempts at uniformity on the other. Its watchword is unity in diversity."

Baha'u'llah has written that "the time must come when the imperative necessity for the holding of a vast, an all-embracing assemblage of men will be universally realized. The rulers and kings of the earth must needs attend it, and, participating in its deliberations, must consider such ways and means as will lay the foundations of the world's Great Peace amongst men." Concerning the proceedings for this world gathering, the Baha'i writings state that "they must make the Cause of Peace the object of general consultation, and seek by every means in their power to establish a Union of the nations of the world. They must conclude a binding treaty and establish a covenant, the provisions of which shall be sound, inviolable and definite. They must proclaim it to all the world and obtain for it the sanction of all the human race. This supreme and noble undertaking—the real source of the peace and well-being of all the world—should be regarded as sacred by all that dwell on earth. All the forces of humanity must be mobilized to ensure the stability and permanence of this Most Great Convenant. In this all-embracing Pact the limits and frontiers of each and every nation should be clearly fixed, the principles underlying the relations of governments towards one another definitely laid down, and all international agreements and obligations ascertained. The fundamental principle underlying this solemn Pact should be so fixed that if any government later violate any one of its provisions, all the governments on earth should arise to reduce it to utter submission, nay the human race as a whole should resolve, with every power at its disposal, to destroy that government. Should this greatest of all remedies be applied to the sick body of the world, it will assuredly recover from its ills and will remain eternally safe and secure."

Baha'is around the world appeal to the leaders of all nations and to their co-religionists of all faiths to seize this opportune moment and take irreversible steps to convoke this long overdue world meeting. Let men and women, youth and children everywhere recognize the eternal merit of this imperative action for all peoples and lift up their voices in willing assent. Indeed, let it be this generation that inaugurates this glorious stage in the evolution of social life on the planet.

And yet, as essential as permanent peace among nations is, Baha'u'-

llah asserts that it is not the ultimate goal of the social development of humanity which is none other than the unification of all of the peoples of the world in one universal family. "The well-being of mankind," Baha'u'llah wrote, "its peace and security, are unattainable unless and until its unity is firmly established." The Baha'is offer their own experience as an example of a community drawn from many nations, cultures, classes and creeds, engaged in a wide range of activities serving the spiritual, social and economic needs of the peoples of many lands. We hold firmly to the conviction that all human beings have been created "to carry forward an ever-advancing civilization" and that the virtues that befit human dignity are trustworthiness. forbearance, mercy, compassion and loving-kindness towards all peoples.

We convey the anxious plea of our co-religionists everywhere for peace and unity. We join with all who are the victims of aggression, all who yearn for an end to conflict and contention, all whose devotion to principles of peace and world order promotes the ennobling purposes for which humanity was called into being by an all-loving Creator.

I hope that in some small way these principles of the Baha,i Faith on the promotion of world peace which I have shared with you today will contribute to the worthy objectives of this international conference on ethics and human values in health policy. We must all arise to bring about world peace and ensure that religion becomes the very source of the unity of mankind which is the foundation of a lasting peace. The Baha'i writings state that "the Prophets of God should be regarded as physicians whose task is to foster the well-being of the world and its peoples, that through the spirit of oneness, they may heal the sickness of a divided humanity." Let me close with the words of Baha'u'llah who emphatically promises that "these fruitless strifes, these ruinous wars shall pass away, and the 'Most Great Peace' shall come." □

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Challenges Facing Health Care Priorities in Developing and Underdeveloped Countries

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In the XVIII CIOMS Conference on HEALTH POLICY, ETHICS AND HUMAN VALUES, we focused on the problems of ethics and human values resulting from the rapid progress in medical technology. We deliberated on the ethics of prolonging life with the help of machines; we focused on the exact meaning and definition of clinical death; and, we discussed the moral aspects of organ transplants and tube pregnancy. These are questions that are of primary concern to the industrially advanced and developed nations.

The media, however disseminates with abandonment, information concerning these issues to developing and underdeveloped nations, thus proving a potent source for dissonance. In reality, the developing and underdeveloped countries have different expectations and different value systems with respect to health care. Consequently, the framework of ethics as applicable to these countries takes a different shape. Let me pose these questions to this erudite gathering; and, as I go along, try to identify the underlying ethical and human values.

Prior to the 1960's and before the Alma Ata Conference and the emphasis on primary care, the developing and the underdeveloped countries, in their mistaken zeal to usher in what they believe to be "Hi-tech" progress, failed to ask themselves two relevant questions:

1. What is the most cost-effective package of services that is likely to achieve the most relevant and equitable distribution of health care?
2. What is appropriate in this package at this point of time?

Instead of tackling the issues at the grass-root level, the developing and the underdeveloped countries blindly follow the same path of secondary and teritary care, neglecting to build an infrastructure based on preventive medicine. Why? Because the so called elite of the countries, as well as the politicians who are influenced greatly by the Western media, in turn influence the policy making in health care.

It is sometimes assumed that health care facilities in developing countries should be modelled on those found in the more developed countries and that only a few modifications, mainly those related to climatic conditions, should be necessary!

Surprisingly this view is held by many experts who participate in health care projects in developing and underdeveloped countries, but who lack the insight into the problems involved. In the developing and underdeveloped countries, some health workers who have become accustomed to using sophisticated equipment during studies or travels abroad share these views. Similarly some of the decision makers are tempted to incorporate sophisticated technology in order to increase prestige whereas in some of the developed countries the need for this same technology is now beginning to be questioned.

In the developing and underdeveloped countries, the health planners are faced with constraints imposed by:

1. Limitation of financial resources.
2. Inadequacy of manpower.
3. Unrealistic expectations of the professionals and the elite.

Of course these three areas are, by no means, water-tight compartments; on the contrary, they are closely interlinked. However, it will help us to appreciate the problems with clarity if we view these areas, one at a time.

1. Limitation of Financial Resources

The price paid by the developing and the underdeveloped countries for imitating the developed countries and allocating their already meagre resources for the development of secondary care institutions at the neglect of primary care is considerable.

At the very least, it has left unfulfilled the objectives of developing primary health care facilities, equipping them with the manpower that is able to appreciate the real cause of disease and with the ability to communicate with the patient on the same wave length. On the other hand the imported manpower and the few national professionals who have received training abroad in highly developed medical technology are frequently more concerned with secondary and territary care. This attitude naturally proves a drain on the resources of the countries.

The situation is further compound by the outlook of the policy makers who are greatly influenced into believing that only that service which is available in the developed countries is right and will effectively serve the needs of all people. This thinking, unfortunately, has received the backing of the elite in the community who may be easily dazzled by the glamour of "Hi-tech" medical care.

Let me illustrate the dilemma with an almost kindergarden example. Let us suppose a person suddenly fainted in the middle of a street. If this happened in an underdeveloped country chances are the person is suffering from starvation. The solution naturally would be to provide food. On the other hand, if the same incident took place in a developed country, the chap probably fainted from psychic stress and would need a tranquilizer. Imagine the absurdity of juxtapositioning the solutions! Yet this is what we are precisely doing when we blindly follow the path of the developed countries; and, in the process we drain meagre financial resources by allocating them to unproductive channels.

The obvious ethical question confronting the planners is one of identifying priorities for resource allocation. The situation confronting the policy makers is one of limitless needs to be satisfied by a limited budget. The questions still arise: Do we channel our resources into avenues that will ameliorate the health of the majority through emphasing primary care?

Or do we provide the heavy outlay needed for high technology which is of questionable benefit, even for a minor proportion of the population, because the manpower needed for such technology is simply not available in developing and underdeveloped countries?

2. Inadequacy of Manpower

The reliance of developing and underdeveloped countries on imported manpower results in a lopsided manpower mix. The truly competent and brilliant are well taken care of in their respective countries and seldom feel the need to relocate. The developing and underdeveloped countries thus must offer enormous pay packets to attract so called "experts". These are frequently mediocres who can contribute little toward developing a viable system of health care for the developing and underdeveloped country. In an attempt to camouflage their inability to provide the needed expertise, these foreign experts often demand ultra sophisticated and expensive equipment. Very often, by the time such technology is purchased and installed at considerale expense, the people who demand it have left the country, leaving the developing or underdeveloped country literally "holding the baby". The fresh batch of imported experts, for their own survival, naturally must point out how erroneous are the ways of their predecessors! So the viscious cycle goes on:

Constraints in Budget
Constraints in Manpower
Poor Health Planning
Further Drain on Resources

3. Unrealistic Expectations of the Elite and Professional

The developing and underdeveloped countries are trapped into looking at progress through coloured glasses because of the prevalence of what I would like to call "THE WHITE SYNDROME". Throughout these countries, the following currents of thought permeate:

You have a right to call yourself educated and belonging to the top echelons only if you speak the language of the "White Master".

Advice coming from the "White Master" is to be taken as 'gospel truth' and blindly implemented.

Anything not done in the country of the "White Master" is not worth considering.

The "WHITE SYNDROME" naturally gives rise to unrealistic expectations and false value systems.

If we cannot build mammoth secondary and tertiary care hospitals, fully equipped with the latest that money can buy as advocated by the propaganda machines of the "White Master", we are made to feel ashamed of our health facilities.

Is it ethical to brainwash the policy makers of the developing and underdeveloped countries into accepting the "WHITE SYNDROME" to such an extent that the meagre number of the countries' own professionals are rendered incapable of functioning without the aid of highly developed technology?

What is even more distressing is the dissemination of medical miracles by the media, which more often than not related to a few isolated results obtained in animal experiments! When the media bombards us with the message of a breakthrough in medical technology—the promise of restoration of sight to the blind or morbidity to the lame, you can imagine the anxiety such misleading information can generate in a country where the basic problems of malnutrition, poor hygiene and lack of immunization must be tackled. I leave these ethical issues to you for your pondering and evaluation.

Admist this scenerio of developing and underdeveloped countries, the Gulf Countries find themselves in a peculiar situation. We are still development with respect to expertise and trained national manpower. However, unlike some of the developing and underdeveloped countries, we have the financial resources for building secondary and tertiary care hospitals for the importation of expensive, though perhaps, unstable manpower.

You will get a clearer picture of the existing global scene regarding problems of health priorities and constraints with respect to developed developing and underdeveloped countries with the graphic representation on the following page.

In summary, if the developing and underdeveloped countries wish to use their limited financial resources to provide health care in relation to needs, these needs will need to be considered in relationship to:

Allocation of limited resources in relation to these needs.

Inadequacy of manpower, especially in terms of commutation of labour.

Unrealistic expectations of the elite, professionals and policy makers regarding the true goals of health care programs.

If we are to be truly successful in providing the health care needs for the developing and underdeveloped countries, limited resources must be carefully distributed and monitored to maintain their applicability within the goals; manpower must be made aware of the needs and goals and in turn become committed to those needs and goals; and, the expectations of the elite, professionals and policy makers must insure that the true goals run parallel with the ethics and human values of the country. ☐

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To Tell or Not to Tell

Professional practices in the care of the dying

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Abstract

Sixty five responses of postgraduate doctors practising in India to a questionnaire on their beliefs and practice about telling the truth of inevitable death to their patients were studied. A majority (69.2%) favoured in telling the truth. Around 50% of their patients were suspected to be aware of their fate without being told. 40% of the doctors had had one or more occasion of feeling sorry later on because of their hiding the truth.

Introduction

Doctors differ in their approach about how much and when to tell the truth to the patient while caring for the dying. Some doctors have their own dogmas on this issue while others are guided by circumstances. Those who believe in telling the truth are usually critical of others who are evasive and use lies; but they themselves are considered unkind by the others.

There are few studies on medical perspective in the care of the dying from our country though in the West it has attracted both the professionals and the lay.[1,2] Issues and ethics while dealing with death in India may not be the same as in the Western countries in view of wide differences in social, cultural and religious beliefs. How do the doctors in India deal with patients facing inevitable and/or impending death ? We undertook a study with the help of a questionnaire on practicing doctors. One hundred ex-postgraduate students of the Postgraduate Institute of Medical Education and Research Chandigarh (PGI, Chandigarh), now practicing in the field and forty non PGI Alumni, Indian Medical Association members were sent the questionnaire. Since only three of the 2nd group responded we excluded them from the final analysis. Sixty five of the PGI alumni responded to the questionnaire.

Results

The responses were grouped into two categories depending upon their belief in telling the truth about the disease and its outcome to their patients :

Group I : Those who believed in telling the truth (45 : 69.2%).
Group II : Those who did not believe in telling the truth (20 : 30.8%).

The reasons favoured by those in favour of telling the truth were : (i) It pacifies the patient who can accept death more peacefully (61.5%); (ii) it helps in more effective palliative treatment (81.5%); (iii) the patient can put the family problems like marriages, transfer and division of assests etc. to order before death (90.8%); (iv) the patient can fulfil the last wishes (76.9%); (v) it stops their running around to seek treatment from different sources (93.8%). Other reasons included economic reasons (i.e. to give an expenditure versus result ratio to the patient), easier handling by the family and the patient's right to know the truth.

Those who were not in favour of telling the truth favoured the following reasons : (i) it frustrates and angers the patient (86%); (ii) it makes the family member's job more difficult (60%); (iii) it is difficult to tell the hard truth (60%); (iv) the patient may turn to quackery (50.8%).

Group I doctors (90.8%) felt that the truth should be told by the treating physician only. But 40% of group II doctors thought that if it has to be told it should be told by some one else eg. a close friend, relative or a priest.

About the awareness of the patient without being told 60.8% in group I and 72.3% in group II thought that over 50% of their patients knew of their fate.

Only 18.5% had ever felt sorry once or more afterwards about their decision of informing their patients. But 40.0% had one or more instances of feeling sorry afterwards when they did not inform the truth. This was because the patient kept wandering from place to place in search of cure and spent a lot of money (21.5%), could not settle worldly affairs (9.2%), or could not complete the last wishes (9.3%). Two doctors admitted of facing official and/or legal problems in view of their not telling the truth. However, none was ever charged in the court of law.

Discussion

It is generally believed that the knowledge of death takes away the charm of living. On the other hand, such a knowledge may dispel the uncertainty and may give the courage to face the situation. In the Western experience around 50% of the patients are already aware of their impending death.[3,4] In one study on the dying patients over 60% knew of this fact and none disapproved of open discussion.[3] Our results are similar to these findings. Most of our doctors have preferred a flexible policy of discussion guided by 'situation ethics' i.e. adapting the ethical standards to the situation. A majority of them would like to discuss the truth.

Involvement of the family members and the close relatives was favoured by most of the doctors. In view of the family structure and relatively closer ties amongst relatives in Indian set up, this aspect is of obvious importance.

It may also be worth recalling that 40% of the doctors had felt sorry at least once each about their hiding the truth from the patient. The most important reason here was their failure in giving the patient an opportunity to put the worldly affairs in order. This point again needs to be stressed in our context especially when the head of the family who is often the sole bread earner of the family and usually the only knowledgeable person about family assets, debts, loans and other issues, is sick and dying. Many an official, procedural and legal complications can be avoided if these things are settled or atleast informed to the kith and kin before death. The patient also needs to know before hand about the utility of the expenditure involved in treatment versus the result as the family income may be meagre. Above all, a doctor is legally obliged to tell the patient the whole truth and nothing but the truth.

'The truth' of course 'has a broad spectrum with gentleness at one end and harshness at the other. Patients always appreciate gentle truth.[4]

References

1. Symposium (1973) 'Care of the Dying' Br Med J 1, 29-41.

2. Lamerton R (1973) Care of the Dying. London Priory Press.

3. Hinton J (1974). Talking with people about to die. Br Med J 3, 25-27.

4. Thomson WAR (1977). Care of the Dying. In : A dictionary of medical ethics and practice. John Wright & sons Ltd. Bristol. p. 107-110.

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Euthanasia

Dr. H.N. Shukla

Introduction

Euthanasia has its origins from a Greek word, the term 'Eu' means 'Well' and 'Thanatos' means death and it literally means an easy death. It is a form of peaceful or dignified death which is specially advocated when life become a punishment and dying comes as a pleasure to a patient, suffering from some incurable disease like cancer with severe intolerable and uncontrollable excruciating pain, who more often tearfully pleads to a doctor to relieve his suffering soul from bodily cage. The conflict is often stated to be between the doctor's duty to treat to the best of his ability and patient's right to be allowed to die quietly and in peace, when further medical measures appear meddlesome and only prolong suffering. Health Council of Netherlands has defined Euthanasia 'A deliberate life-shortening act or deliberate omission of a life lengthening act, in respect of an incurable patient and in his interest'. This definition includes both active (life shortening act) and passive (omission) euthanasia. The 'Declaration of Venice' at the meeting of the World Medical Association in Oct. 1983, has laid down that 'Physician may relieve suffering of a terminally ill patient by withholding the treatment with the consent of the patient or his immediate family member in case the patient is unable to express his will' and 'The physician may refrain from employing any extraordinary means which would prove of no benefit for the patient'.

In the light of above the present article endeavours to stress the role of Voluntary Passive Euthanasia in the Terminal Care, especially the withdrawing of life sustaining treatment according to wishes of patients suffering from Terminal Illness and withdrawal of life sustaining aids from a Terminally Injured patient after declaration of brain death. It will be in public interest for such a measure to be enacted as it would relieve a certain number of patients from suffering pain and torments which can be avoided.

Good death : Moral and Legal Challanges in Terminal Care

Law and medicine join a common pilgrimage towards protection, preservation, regulation, care, and all-pervasive welfare of human life. The Indian Constitution (Article 21) assures that 'No person shall be deprived of his life by the state except according to the procedure established by law'. The constitution can guarantee the 'Security' or 'Non-interference' in the enjoyment of life but no constitution in the world can ever assure its citizens that their life would remain always free from pain, disease and physical and mental agony. The right to life protected by Indian Constitution has not been judicially held to include 'Right to die'. The question is whether a person who has become a mere vegetable mass of protoplasm, who has worse than animal existence, who has no hope of recovery—

Should he be forced to live ? Should he be not allowed to die peacefully without suffering from further physical and mental agony ? Cannot he ask the state that while he has been given right to life, Can't he be endowed with a right to die in the event of a terminal illness or terminal injury ? The death sentence in India has been held to be constitutional under the very provision which protects the right to life of a person. Likewise state has legalised the Medical Termination of Pregnancy. Interaction of law and medicine is notable in cases of abortion. It is now perfectly legal though may not be perfectly moral or ethical. Man can choose to give life or death to the helpless unborn child then why should he not have similar right for his ownself ? The legislation of abortion means legislation of 'Death' of an unborn person. The purpose of abortion in most cases is to safe guard the health of a pregnant woman or it is for the convenience of the society and state as a measure of population control but the voluntary passive euthanasia is for the sake of suffering 'individual'. If law can permit 'killing' of an unborn child for the sake of 'others' Why should it not allow voluntary passive euthanasia for a willing and suffering patient.

Role of Voluntary Passive Euthanasia in Terminal Care

Terminal illness or Terminal Injury means any incurable illness or injury which will in all probabilities result in the expiration of life, regardless of use or discontinuance of medical or surgical treatment. To day cancer accounts for 15 per cent of deaths in the world. In U.S. alone more than 7 million unfortunates are in grip of this dreaded affliction. It is here that Voluntary Passive Euthanasia becomes relevant. Voluntary Passive Euthanasia advocates compassion in the preceding stages of terminal illness. These stages are process of dying which sometimes linger on for years. When a doctor prolongs the life of a dying patient by days, weeks, months or by years he merely prolongs his life of suffering. He simply promotes his vegetable existence or adds to his comatose condition in the name of preservation of life. No patient wants to put up with sufferings indefinitely. There is an innate desire in all living beings to terminate their sufferings as quickly as possible. When the intensity of suffering is beyond the pale of human indurance the urge to extinguish life is paramount. Prof. Elizabeth Ross recognises this final state of dying as a stage of acceptance, the patient is ready to accept loss of his life and beloved ones.

Withdrawing of Life Sustaining Treatment in Terminal Illness

The life sustaining treatment means all artificial means or measures of whatever kind administered as medical or surgical treatment designed solely to sustain life process. In developing nations health expenditure on the last few months of patient's lives rises to a crescendo, as might be expected but the consumer, the patient, often seems to derive little of real personal value from the money thus spent. Traditionally the medical ethics has been helped at this point by distinguishing 'ordinary' means of treatment which should be available to all patients, from 'extra-ordinary' which should not be employed as they cannot be used without excessive pain, cost or other inconvenience and which offer no reasonable hope of benefit.

Many people today have a fear that they will be kept alive artificially in this manner with consequent suffering and distress to them and members of their family. Since the decision to reject such treatment should be of patient alone and no one else in case of terminal illness as such provision of Voluntary Passive Euthanasia in terminal care will enable doctors, in the interest of compassion and humanity to respond to the patient's wishes in suitable cases but it should not provide for mercy killing of any kind.

Declaration for withdrawal of Life Sustaining Treatment

Any person of sound mind shall be entitled to make a declaration and give powers of Attorney duly executed by such person expressing the desire that if at any time in future he or she were to suffer from a terminal illness or terminal injury and be unable to express himself or herself, the wish embodied in the declaration and power of Attorney regarding withdrawal of life sustaining treatment, shall, if it has been in operation for 30 days and has not been duly revoked in writing be given effect to by his physician or surgeon and members of his or her family.

Withdrawal of life sustaining aids in patients of Terminal Injury

A person who can be declared dead under the law in U.S.A. and U.K. is considered to be alive in India. Though this may appear illogical, it is true because brain death is not legally recognised as death of a person and our law is silent on the issue of brain death. The main problem arises in road traffic accident victims who are being maintained on continuous artificial respiration by means of mechanical ventilators after sustaining irremediable structural brain damage. In such patients doctors are not lawfully authorised to switch off the respirator.

Legal recognition of brain death will enable doctors to withdraw life sustaining aids including the respirator, in patients suffering from terminal injury the moment brain death is diagnosed, especially in patients who failed to make any declaration in life time or execute powers of Attorney, expressing their wish for withdrawal of life sustaining aids in the event of terminal injury.

Diagnosis of Brain Death in Terminal Injury

The code of practice as agreed by Conference of Royal Medical Colleges and their Faculties of United Kingdom (1976) has advised the medical practitioners that before considering the diagnosis of Brain Death three conditions should be present altogether :—

1. Patient should be deeply comatose :
    - (a) There should be no doubt that this state is due to depressant drugs.
    - (b) Primary Hypothermia as a cause of coma should be excluded.
    - (c) Metabolic and endoctrine disturbances that may cause or contribute to coma should also be excluded.

2. Patient should be maintained on continuous artificial respiration by means of a mechanical ventilator.

3. There should be no doubt that patient's condition is due to the irremediable structural brain damage for example severe head injury.

Tests for confirmation of brain death

(i) All brain stem reflexes should be absent.

- (a) Pupils are fixed and dilated and do not respond to sharp changes in incident light.
- (b) Corneal reflex absent.
- (c) Vestibulo-ocular reflex absent.
- (d) Carinal reflex absent.
- (e) Gag reflex absent.
- (f) No motor response within cranial nerve's distribution can be elicited by adequate stimulation of any somatic area.
- (g) Spontaneous respirations—Absent with a normal P_aCo_2, in the absence of hypothermia.
- (h) The oculo-cephalic reflex or doll's head eye movements must be absent.

Other Considerations

- (i) Repetition of Testing—It is customary to repeat the tests to ensure that there has been no observer's error.
- (ii) Integrity of Spinal Reflexes—It is well established that the spinal reflexes may perist after brain death (Ivan Smith 1973).
- (iii) Confirmatory Investigations—It is now widely agreed that E.E.G. (Electro-encephalography) is not necessary for confirmation of brain death.
- (iv) Body Temp.—It is recommended that body temp. should not be less than 35° C before the diagnostic tests are carried out.

Advantages of Legal Recognition of Brain Death in Terminal Injury

(A) *Responsibility of a Doctor* : Normally a doctor is not lawfully authorised to switch off a respirator sustaining the artificial respiration of a terminally injured patient, lying in a state of coma after sustaining the irremediable structural brain damage. If a doctor switches off the respirator at his own, he will be charged for causing death by an omission. The recognition of Brain Death legally as death of a person, will save the doctors from responsibility in such cases of terminal injury.

(B) *Organ transplantation* : The recognition of brain death of a terminally injured person in law will enable to the act legally and correctly in the field of organ transplantation. After the confirmation of brain death if a surgeon has to keep on waiting for cardiac arrest to occur before removing organs for transplantation, a recipient may well receive a damaged organ and a recipient grafted with a damaged organ will have to undergo the pain, danger and suffering from two useless operations, namely one for the insertion of the graft and the second for its subsequent removal. The most suitable donors for organ transplantation are terminally injured patients, usually the road traffic accident victims who are being maintained on continuous artificial (IPPR) respiration by means of mechanical ventilators after sustaining irremediable structural brain damage. Such people have been organ donors either in their life times or consent has been obtained from their relatives. In U.S.A. such patients are also known as heart beating cadavers. Recognition of brain death as death of such terminally injured patients will enable doctors to remove the organs from such decerebrate donors. Normally transplants cannot be lawfully taken away from a living body if donor can not remain alive without the part being taken i.e. heart, so for a successful heart transplantation it is to be removed from a heart beating cadaver only. The most appropriate time for organ removal is before the vital life support system is withdrawn and organs are well perfused. Moreover heart has been kept alive and functional up to 56 hours after brain death, a duration of time which is long enough for operative exploration, tissue typing and search for a suitable recipient.

(C) *Economy of Intensive Care Resources* : Legal recognition of brain death as death of a person in case of a terminal injury will help in economising the intensive care unit's resources in the country, which are being strained by providing trained man power, intensive care unit beds and respirator for ventilating these brain dead people who have suffered from brain death after terminal injuries.

(D) *Property Rights* : Legal recognition of brain death as death of a person will have maximum impact in the matter of property rights, negligance claims, insurance, worker's compensation, probate law and taxes. A corpse cannot have property. Suppose that X is an old man who has left Y a large sum in his will. Y himself has suffered from a terminal injury and is in a state of coma, on artificial respiration at a hospital after sustaining irremediable structural brain damage. Here doctors are not lawfully authorised to switch off the respirator so they ask for consent of relatives but relatives see that Y is kept 'alive' on heart-lung machine because they want X's money. As soon as X dies the respirator off and Y is buried. In this example Y is being considered as still alive when X dies so that his family becomes entitled to property through him. This dodge will not be successful if Brain Death is legally accepted as death of a person.

The fact remains although the diagnosis of death is medical, its definition must be legal. The law protects the living but ceases to protect the dead (at any rate in the same way) and the line between the two must be drawn by law. The definition of death presented herein may suit both medical as well as legal requirements because it does not interfere with the existing procedure of declaration of death but at the same time it includes. the concept of Brain Death in a terminally injured at the hospital level in the light of the current knowledge on the subject.

Definition of Death

'A person may be pronounced dead, whether inside or outside a hospital if based on usual and customary standards of medical practices, it is determined that the person has an irreversible cessation of cerebral, cardiac and pulmonary functions or a person inside a hospital only can be declared dead if having suffered from irreversible structural brain damage, his or her bodily functions cannot be maintained without continuous artificial support, provided the diagnosis of Brain Death in such a patient is based on diagnostic criteria as agreed by conference of Royal Medical Colleges and their Faculties of United Kingdom resolved in 1976'.

The above definition of death will be the most appropriate, not only for declaration of death in a terminally injured patient who has suffered brain death due is irremediable structural brain damage but will also pave the way for uniform determination of death in our country.

However it must be emphasised that for declaration of brain death opinion of two doctors must be obtained out of which one should be the consultant incharge of the case and the second may be any other doctor, incase the consultant is not available then his deputy who should have atleast five years of experience in dealing of such cases after his registration and none of the doctors who declare the brain death in such a patient should be the members of transplantation team in case the organ removal has been planned for transplantation.

Summary and Conclusion

Good medical care includes providing good death in a terminally ill or terminally injured patient. The dying patient must be considered competent in terms of capacity for autonomous choice unless proved otherwise. Medical science has now acquired life supporting systems and medications to extend life artificially for long periods even after loss of brain activities and control of bodily functions. Many people today have a fear of mind that they will be kept alive artificially for indefinite periods of time with consequent suffering and distress to them and members of their family. The conflict is often stated to be between doctor's duty to treat to the best of his ability and patient's right to die with dignity, quietly and in peace when further medical measures prove ineffective and only prolong suffering. Introduction of voluntary passive euthanasia in Terminal Care will not only relieve a certain number of patients from suffering pain and torment which can be avoided but will also enable the doctors to respond in the interest of compassion and humanity according to wishes of patients suffering from terminal illness and terminal injury. In case of a terminally injured patient who fails to make a declaration or execute powers of Attorney in advance expressing his wish to withdraw the life supporting treatment legal recognition of brain death will enable doctors to withdraw the life sustaining aid in a terminally injured patient after the declaration of brain death. Such a measure legalising brain death as death of a person in the event of terminal injury, will be in public interest, for such a measure to be enacted will not only protect doctors from needless prosecution and persecution but but will also have numerous other benefits i.e. It will help in the field of organ transplantation by permitting removal of organs either with the consent of their relatives or with their own consent in case they happened to be organ donors in their life times, from these terminally injured patients at a time when they are being sustained on continuous artificial respiration after suffering from irremediable structural brain damage and their organs are well perfused; secondly it will help in economising intensive care unit's resources of the country which are being strained by providing trained manpower, beds and respirators for ventilating these heart beating cadavers, thirdly it will secure a doctor's right to switch off the respirator in a terminally injured patient after the confirmation of brain death in the light of current knowledge on the subject lastly it will help in the matter of property rights, negligence claims, insurance, worker's compensation, probate law and taxes. ❑

References

1. Harward (1968) : Report of Ad Hoc Committee of Harward Medical School to Examine the Definition of Brain Death, Definition of Irreversible Coma. J. Amer. Med. Asso. 205, 337.

2. Forrestor, A.C. (1976) : Brain Death and donation of cadaver kidneys Hlth. Bull. (Edinb.) 34, 199.

3. British Medical Journal (1975) : Brain Death. 1, 356.

4. Ivan, L.P. (1973) : Spinal Reflexes in cerebral death, Neurology (Minneap) 23, 650.

5. Jonnett, B. (1975) : The donor doctor's dilemma, observations on recognition and management of brain death, J. Med. Ethics. 1, 63.

6. Lancet (1974) : Brain Damage and Brain Death, 1, 341.

7. H.C. Churchill-Davidson (1984) : A practice of anaesthesia, 5th Edn. Lloyd-luke ltd. London, Brain—Death, 759-60.

8. Mohandas, A. and Chou. S.N. (1971) : Brain death a clinical and pathological study. J. Neuro. Surg. 35, 211.

9. Glanville-Williams (1978) : Text Book of Criminal Law, Stevens and sons. 234-35.

10. Criteria of Death (1984) : Report of consultation workshop, FIAMC Bio-Medical Ethics Centre Bombay. 20—24.

11. Roger Higgs (1985) : Dying Well : moral challenges in terminal care, The Practitioner Dec. 1985, Vol. 229, 1073—76.

12. Journal of Medical Ethics (1983) : 'Case Conference' Cutting the thread and pulling the wool—a request for Euthanasia in general practice, 9, 45—49.

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Moral and Ethical Dilemmas in the Care of Critically ILL Patients

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The knowledge explosion in Science and Technology tends to overwhelm us and we get confused in a maze of technicalities and methods often forgetting the patient we are treating and who becomes a conglomerate of signs and symptoms instead of a person. Advances in resuscitative technology have enabled anaesthetists to almost indefinitely prolong the life-supporting systems of critically ill patients who would formerly have been pronounced as dead after simple traditional measures had failed. The dilemma lies in the moral and ethical necessity of providing maximal care for patients who are terminally or irrepairably ill but who have a chance to survive their present catastrophe (Declaration of Helsinki, 1964). It is agreed that permanent functional death of the brain stem constitutes brain death and further artificial support is fruitless and should be withdrawn (Honorary Secretary, 1976).

In a dilemma one is faced with two alternative choices, neither of which seems a satisfactory solution to the problem. They arise in situations of uncertainity and ambiguity when the general principles upon which one normally relies either offer no help or seem to contradict each other. Such decisions have to be distinguished from the many important clinical decisions which must also be taken by doctors. These decisions may present as dilemmas but their resolution is dependent solely on the doctor's knowledge, experience and intuitive abilities. All these factors are certainly helpful in a moral dilemma but are insufficient to unravel the moral conflict, because a different kind of decision has to be made. The more concerned the profession has become about the formulation of codes of ethics the more they have become aware of the complexity of the moral problems. The profession simply provides some generalised statements in everyday language and leaves it to the good sense and good will of its practitioners to deal with the ambiguous situations.

The individual conscience is thought of as a kind of inner voice warning you against wrong doing and creating remorse when the warnings have been disregarded. Following conscience is the most common way doctors seek to solve the moral dilemmas they encounter. Peoples' intuitions' about right and wrong often conflict sharply. It seems that conscience is a powerful force in controlling the actions of most individuals; but although powerful, it may not always be right.

There is confusion about what is useful and advantageous to the majority and what we feel all men ought to value. Treating every individual justly usually does benefit society as a whole. Respect for the rights of individuals is a more fundamental moral value than the happiness of the majority. We are still primarily concerned with caring for people and the art of medicine should not be forgotten in the enthusiasm for scientific precision. Sympathy and understanding are just as important as diagnostic acumen (Payne 1978). However, in many dilemmas of personal and social morality the criterion of general happiness is a good corrective to personal bias and idealistic mounting of principles.

What we appear to be searching for is a set of absolute or fundamental values which will clearly and unambiguously inform our choices and decisions in any given situation. Such a calculus of human rights cannot and will not be done. Rule following, much of it habitual and unquestioned, characterizes a high proportion of our daily activities. Our behaviour is confined within the limits of the socially acceptable, the legally sanctioned and the routines of personal preference and conviction. A rule-governed approach to morality becomes a wholly depersonalised one. What is missing is any consideration of the persons who hold the principles and the persons to whose circumstances the principles are applied.

It is said that Hipprocrates forbade the administration of remedies to those who were past hope. This injection we may heed as advice not to make difficult the final stages when we recognise their finality. None can relieve us of the responsibility of judging when this moment shall have come. We should bring to the beside a great hopefulness, a determined optimism, but is the futility of the struggle is clearly evident, then we should put aside our remedies as cures, and make the patient easy with such solation as may offer (Gavey 1950). We are asked to give guidance, to judge dispassionately upon reasonable probabilities. The fact that many of our prognosis prove wrong should not detract from a genuine attempt at a correct forecast. As Osler said "Errors of judgement must occur in the practice of a art which consists largely in balancing probabilities".

The question: "should the doctor tell?" is guided in practice by the circumstances of each case which suggests the line that should be taken. In general, a guarded prognosis slowly revealed enables a patient to prepare himself, retaining a hopeful attitude in the background. In these matters few demand to know the truth and nothing but the truth and even if a direct question is asked the patient usually welcomes an answer which does not shut out all hope. The patient senses the true position far more accurately than one might imagine and any attempt to soften the blow is welcomed. There are occasions when it is best never to disclose the true position, even at the end. The human capacity for self deception is great and this characteristic needs to be promoted occasionally.

Intensive medical care is designed to diagnose, treat and maintain patients with immediate, acute but potentially reversible life-threatening impairements. It also aims at prophylactic management to avoid such catastrophes as cardiac arrest, respiratory arrest, shock, renal failure, and overwhelming sepsis. There is a growing beleif that medical and technological capabilities should not necessarily be used simply because they exist.

Is there an ethical imperative to preserve all patients in life threatening situations including those for whom existence seems only a fiction and others for whom it promises to be only severely diminished? On one view, it is justificable to moderate the therapy even though earlier death will occur, when this will result in relief from pain and suffering. Another view is that 'our training is to preserve life and functions whenever possible'. We are not trained to decide who "is better off dead". The patient who is alive has an overriding right to life and deserves the maximal possible therapy (Cohen, 1977).

This conflict has implications for the care of those who are not terminally ill, but who are potentially salvageable with the chance that survival will be accompanied by severe physical or mental impairement or both. It is these difficult cases concerning the level of salvageability that lead to the widest divergence of opinion. The problems are complicated by the fact that it is often not possible to evaluate the likely outcome of intensive care treatment until the patient has been monitored for some days and even then, predictions are open to revision in many cases (Cullen et al, 1976, Griner, 1973). It is also to be remembered that there is a moral difference between "Killing' and 'letting-die'. Dying is the final event of a valuable human being and no one else is morally empowered to initiate and transact. When a decision has been made that maximal treatment is inappropriate it is not an acceptable ethical alternative to kill the patient, but it is permissible to allow the patient to die (Mc Cormic, 1974).

Western ethical traditions have reached some general agreement that it is necessary to use 'ordinary' but not 'extraordinary' means to support and comfort patients in such cases (Pope Pius XXI, 1958). By 'ordinary' means is meant 'all medications, treatment and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expenses, pain or other inconvenience'. 'Extraordinary' means are those that do not offer such hope or cannot be obtained or use without those kinds of liabilities. There is a professional and moral relationship entered into with each patient admitted for intensive care in which it is understood the patient will receive appropriate care. Such care cannot be terminated later on the grounds that another patient with a higher potential for survival needs intensive care without violating the original obligation to the admitted patient and without violating the ethical principle that we cannot aid some by harming other (Report of Clinical Care Committee, 1976).

Survival though important, is not to be bought at any cost and that to attempt, but fail to achieve, may reduce so-called intensive care management merely to the level of prolonging the process of dying (Rabkin et al, 1976). It is of primary importance from an ethical perspective to determine whether the right to life is absolute or whether it can ever be overridden with justification. Our conclusions will not apply with absolute finality, like mathematical equations, to all cases as individuals have very different conceptions of how to exercise their right to the pursuit of happiness within the limits of the ethically possible. Reverence for life must be tempered by restraint and an equal respect for the dignity of death. In the last analysis, our choice is influenced by the way the personality regards it destiny and our own conception of death. ☐

BIBLIOGRAPHY

1. A Report of the Clinical Care Committee of the Massachusetts General Hospital. Optimum Care for Hopelessly Ill Patients. New Engl. J. Hed. 295:362,364, 1976.

2. Cohen, C.B.: Ethical Problems of Intensive Care. Anaesthesiology. 47:217-227, 1977.

3. Cullen, D.J., Ferrara, L.C. and Briggs, B.A.: Survival hospital charges and follow up results in critically ill patients. New Engl. J. Med. 294:982, 987, 1976.

4. Declaration of Helsinki. Brit. Med. J. 2: 177, 1964.

5. Gavey, C.J.: The Management of the 'Hopeless' case. Buckston Browne Prize Essay. E and S. Livingstone, Edinburg, 1950.

6. Griner, P.F.: Medical intensive care in the teaching hospital: Costs versus benefits. Ann. Int. Med. 78:581-585, 1973.

7. Honorary Secretary of the Conference of Royal Medical Colleges and their Faculties in the U.K. on 11 October, 1976: Diagnosis of Brain Death. Brit. Med. K. 2:1187-1118, 1976.

8, McCormick, R.A.S.J.: To save or let die. The dilemma of modern medicine. J.A.M.A. 229:172-176, 1974.

9. Payne, J.P.: Ethical Problems in Clinical Research and Intensive care. Brit. J. Anaesthesia. 50:413-414, 1978.

10. Pope Pius XII. Amer. Q. Papal Dec. 4:393, 1958 quoted by Bishop, V.A.: A Nurse's view of ethical problems in Intensive Care Clinical Research. Brit. J. Anaesthesia, 50:515-518, 1978.

11. Rabkin, MT., Gillerman, G., and Rice, N.R.: Order not to resuscitate. New Brit. J. Med. 295-364, 1976.

12. Resolution 613: On the Rights of the Sick and Dying. Parliamentary Assembly of the Council of Europe, 1976.

13. Safar, P. and Grenwick, A.: Critical Care Medicine, Organising and Staffing Intensive Care Units. V Chest. 59:535-547, 1971.

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Terminal Care–Ethics and Cultural Aspects

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Mankind is subject to the experience of physical death. The death is a state or condition with an existence for man beyond the grave, difficult to describe or quantify. Terminally ill (dying) means that the patient has an illness has which been accurately diagnosed, and which seems certain to bring about his death within a relatively short period of time, since the illness is beyond both cure and palliation. Caring for dying patients and giving sympathetic support to breaved families are profoundly important parts of the work of doctors, nurses and other members of the caring professions. The care of patients during their terminal illness over various periods of time is a privilege, for they greatly appreciate the visits of the doctors and realise they are not forgotten. They may be cared for in hospitals, nursing homes, or family homes and is requires numerous medical and nursing skills according to the particular illness. Symptoms are treated so that the patient remains free from pain and in comfort. Much nursing care is required by some patients, especially those who are paralysed in various ways.

Guidelines for Delivering Bad News

Every physician derives satisfaction from delivering good news to a patient; and no physician enjoys delivering bad news. Still, there are rare occasions when it becomes necessary for the physician to disclose a crippling diagnosis and prognosis to the patient. There are some general guidelines for delivering bad news as follows:

1. *Keep it simple.*
2. *Don't deliver all the news at once.* It is good idea to try not to provide too much information at the first sitting.
3. *Educate the patient gradually and gently* regarding the diagnosis.
4. *Wait for questions from the patient.*
5. *Ask questions yourself*—Valuable clarifications can result from gentle, and clear questioning.
6. *Do not destroy all hope.* "Most people with this form of disease as chronic renal failure are living longer but are not cured of their disease" is a useful kind of statement.
7. *Do not say anything that is not true.* This would be the cruelest blow of all.

I have the responsibility of caring for many patients with various end stage renal diseases; this particular diagnosis understandably causes unrest and anxiety to the patient and family. Various questions require answering at all stages of these illnesses. An explanation about the treatment and prognosis is given to the family, with the assurance that every thing will be done to help the patient throughout the illness. The question whether the patient should be told he or she has end stage renal disease needs some discussion. Information is given with sympathetic understanding of the situation and in the kindest way, in the presence of near relatives Words are chosen carefully to create faith and confidence, and nothing shall be said to take away a patient's hope. I believe we can work professionally in a more helpful way when patients are told about the terminal illness, and by understanding something about the problems to be solved they can cooperate usefully.

Emotional Aspects of Death and Dying

In a critically ill and dying patient, palliation and emotional support are the optimal strategies. A useful approach is to communicate the medical realities to the patient as skillfully, honestly, and clearly as possible and allow the patient with the help of his or her family to decide upon the preferred treatment. Health professionals must have the courage and willingness to acknowledge that the patient's wishes may take priority over their own.

Patient-Doctor Communications

Fundamental to the evolution of effective doctor-patient communications is the notion that physicians answer all questions honestly, giving as much information as is asked by the patient.

Ambiguous or dishonest communication imposes needless emotional pain on patients and families facing life-threatening illness.

A variety of information inputs that come to the patient:

1. Direct statements from the physician.
2. Overheard comments of the physician to others.
3. Direct statements from others including nurses, ward boys and technicians.
4. Statements from family, friends and clergy.
5. Changes in the medical care routines, procedures, behaviour of others towards patients and changes in physical location.
6, Self-diagnosis, including reading of magazines, newspapers, records, charts and books.

It is evident that the dying person is engaged in multiple communications with many people. If the messages are clear the dying person can make sense out of his experience. But if the messages are confused or contradictory, the result is needless apprehension and anxiety. Many patients, once they are aware and acknowledge the untreatable state of their disease, have less pain and discomfort in general and require a minimum of medical supervision.

It is very difficult to answer the questions about the length of time the patient is likely to live, except when the end is obviously neat and I explain that all our lives are in the hand of God. I respect the wishes of the family relatives of non-mentioning of the diagnosis and prognosis to the patient to avoid any upset, although it made more difficult when a patient realises the gradual deterioration of health without a real explanation being given to him. During the final days of the illness, the family members have to be informed about the time becoming short for the patient and by that time majority of these patients know about their condition. Whole family require help at these times to ameliorate the strains and stresses caused by loss of family member.

Patients who are seriously ill and cannot recover by available recent mode of therapy and their families, appreciate the frequent visits of the doctor, who can give much sympathetic help and support to ameliorate the sorrow and suffering which become more intense as death approaches for the loved relations. The presence of the doctor who has become a trusted friend during the illness is a source of solace to them in their grief. A special, unhurried visit following soon after the patients death to take and discuss is greatly appreciated by the family and these visits to the breaved family should continue for a further period of time, until there is an amelioration of their grief and loneliness.

Community Approach to Psychological Support of Dying Patient

The awareness, tolerance and acceptance of the reality of dying is difficult for the patient and family. In order to provide emotional, social and spiritual support, a community-wide effort helps in achieving the maximum care for the patients comfort and psychosocial support. It is important to have people involved, whether social workers, trained volunteers, priests, etc., who can give supportive help to patient and family members.

Bereavement Follow-up

Bereavement leads to a period of crisis, for the family. The care of the terminally ill patient and family does not stop when the patient dies. The members of health team may attend the funeral. Home visits and telephone contact continues with the family within the first three weeks of bereavement and subsequently upto approximately one year. Opportunity for the spouse, parents and children to express their grief and talk about the illness and death does much to relieve guilt and depression. A memorial card is sent to the key person on the anniversary of the death.

Role of Clergy Man or Priest

Not all symptoms need medication in a terminally ill patient. Pain of isolation and inability to attend church and ring with the choir is helped immensely by the presence of clergy man or priest and with the relatives and friends at bed side.

Understanding Patient Depression

Frequently observed patient response to life-threatening illness is depression. It results from:

(i) Prolonged and painful hospitalization and treatment.
(ii) Emotional abandonment by family and friends.
(iii) The real or imagined insensitivity of hospital personnel.
(iv) Depletion of finances due to expensive medical care.

It is not helpful to interrupt this response with false promises of cure or positive response to treatment. Patients require emotional support. One can be extremely supportive by sitting with the patient, often in silence, in an attempt to convey willingness to share this emotionally demanding period.

The Patient's Family

The dying patient and his or her family constitute the optimal unit of health care. It is extremely important for patients to conclude family relationships in as emotionally satisfying a way as possible. It can be very distressing for critically ill persons and their families to be separated by the treatment milieu. Following suggestions are offered to health professionals:

1. Train family members to participate in treatment.
2. Encourage them to do such things as continue to cook special meals for the patient.
3. Allow unlimited visiting so that the total family, including children, can spend time with the patient.
4. Provide special social and educational programs for the family and patient.

Continue these programs, adding home visits for the family after the patient has died.

Despite the importance of care for all troublesome and common symptoms of terminal patients admitted in hospital (100 cases); it remains to be said again that good personal relationships and the prevention of loneliness are of paramount importance in providing high quality terminal care (Table I).

Pain	50%	Dyspnoea	17%
Incontinence	30%	Bed sores	15%
Confusion	20%	Vomiting	13%
Nausea	15%	Cough	5%
Anorexia	15%	Dysphagia	3%
Insomnia	15%		
Depression and anxiety	20%		

The importance of adequate fluid intake, bowel regulation without discomfort and the correction of electrolyte imbalance, must be stressed in the terminal patients as in others. In dealing with all these symptoms, the doctor's enthusiasm and confidence in his therapy will be, without doubt, transmitted to the patient. He should have the same interest in the patient during this stage of life as in any other. It is stressed that whether patient is nursed at home, in an institution, or by intermittent hospital admission and discharge, it is essential to make certain that there is continuity of care.

The management of terminal illness by the family physician is in the exploration and development of the doctor/patient relationship where the feelings of patient and the doctor are fully expressed and understood. A good relationship is best established when the patient and doctor acknowledge, either overtly or covertly, their awareness of impending death and the patient is allowed to test out the relationship without any fear of the doctor withdrawing.

In hospital, the dying patient receives every attention, constant medical and nursing care, the advantages of modern palliatives, profusely planned drug administration for the control of pain and freedom from neglect and loneliness. Very little work has been done to estimate the numbers of patients who die at home compared to those who die in hospital. 90% of all episodes requiring medical and nursing care attentions are dealt with in the community, but it is unlikely that a similar percentage rate applies to death. Once the decision is made, the transfer from hospital to home care should be effectively planned, so that the home, family and the primary care doctors and nurses are all prepared. □

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The Right to Live and The Right to Die

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My good friend, Yusuf Meherally, whose useful life was cut short so cruelly, used to write in every autograph book which was placed before him by his many young admirers : "Live dangerously". In my young days I thought it was a rather good slogan and, by and large, I have tried to live up to it, and never regretted doing so. The idea of death has never worried or frightened me right from my young days. I would much rather be dead than red. What does, however, give me the creeps is the thought of being crippled and unable to function. I know a great many people who share this preference for a quick and dignified death to a long and humiliating existence as a cripple or a vegetable.

At a meeting I addressed on behalf of the Society For the Right To Die with Dignity, which was the first of its kind in India, I was asked by a gentleman who believed in *karma* what advice I would give him. I told him that, as far as he was concerned, he was altogether entitled to endure the sufferings to which he had referred as part of the cycle of karma. Since all we are arguing for was Voluntary Euthanasia, I hoped he would not mind my exercising my option the other way when the occasion arose, since I was not convinced of the reality of reincarnation or *karma*.

Some of my friends find it difficult to accept the thought that, when they die, it will be their final elimination and nothing will remain of them at any level of existence. I must confess that to me the idea of absolute destruction does not hold any terrors, while the idea of going through Purgatory and then facing whatever came afterwards does not appear to be particularly restful after a long and busy life on this earth. Why should one object to being blotted out at the end of this life? Why should I have the conceit that I must go on forever ?

All this shows that our perceptions about the matter of life and death vary greatly and that to deny anyone the right to a different view from what one holds oneself would be not only dogmatic but stupid. We all know so little, about these matters, and it is best to keep an open mind, do the right thing, practice the golden rule, and leave the rest to Providence which, it has been aptly said, "shapes our ends, rough how them how we will".

I have always responded warmly to the English poet who wrote :

> "I am the master of my fate,
> I am the captan of my soul."

I was therefore greatly touched when Mr. Gopal Mandlik, a well-known social worker of Poona, ended his own life in 1980 after waiting two years for the Government of India to amend the Indian Penal Code and to make it possible for him to do so legally. His only regret was that his eyes and his kidneys, which he had wished to donate for humane purpose by deleting Section 309 IPC could no longer be put to use in that manner. He was a true *satyagrahi* in the Gandhian sense. Gandhiji always urged that where one's conscience held a law to be wrong or immoral, the satyagrahi should break the law and take the consequences but not run away.

Mr. Mandlik's brave act was one of the factors that led some of us to establish The Society For the Right To Die with Dignity in May 1981. Another sad case of someone who was not in a position to imitate Mr. Mandlik was that of my good friend Norman Thomas, the American Socialist leader, who was in his old age completely paralysed and pleaded to be released, but was tormented by being kept alive for many years because it was not legal in that particular part of the United States to allow him to die.

When people tell me that public opinion is not ready for an amendment of the law which would make Voluntary Euthanasia easier to practice, under proper conditions and safeguards, I am inclined to wonder. Public opinion has been described as "a fickle jade" and indeed is very volatile and changeable. In the middle of the 60s, a well-known lady who was a champion of birth control in India, pleaded with me not to introduce a Private Member's Bill in Parliament for legalising abortion on the ground that, if I were to do so, it would create such a storm of opposition that the backlash would injure the cause of contraception. Lo and behold, four or five years later I found myself a member of a Joint Select Committee of Parliament which recommended to Parliament the legalising of abortion, and I noted that nobody in the Select Committee and nobody in Parliament opposed this change in principle. How do we then know what public opinion is or not in the case of Voluntary Euthanasia unless we first educate it and then test it ?

That is precisely what our Society has tried to do in the years that have passed since we took this pioneering step. There has recently been a great deal of public discussion on this issue.

Much of this is due to a Bill introduced by Prof. S.S. Varde in the Maharashtra Legislative Council to provide for immunity and protection to physicians and surgeons who withdraw life sustaining treatment from terminally ill patients at their wish. This Bill was ordered to be circulated by the Council to elicit public opinion and this led to a controversy in the course of which prominent doctors in Bombay including Dr. Praful R. Desai, Director, Tata Memorial Centre, Dr. N.H. Keswani, Medical Director, Jaslok Hospital and Research Centre, Dr. B.N. Colabawala, Dr. R.R. Soonawala. Dr. K.D. Desai, Dr. F. Soonawala, Dr. J.C.N. Joshipura, Dr. V. Talwalkar and others have written to the press welcoming the Bill.

The other helpful development is a judgement of a Division Bench of the Delhi High Court on March 31st 1985, which refused to punish a young man who attempted to commit suicide despite Section 309 of the Indian Panel Code which makes such an attempt punishable.

In an outspoken judgement, the Delhi High Court has held that Section 309 of the IPC is an anachronism unworthy of a humane society like ours. The High Court went on to observe that many penal offences were the offshoot of an "unjust" society. 'So long as society refuses to face this reality, its coercive machinery will invoke the provisions like Section 309 IPC which has no right to remain on the Statute Book". The Court said that "the young man (Sanjay Kumar Bhatia) who tried to commit suicide because of "over emotionalism" would have escaped human punishment if he had succeeded in taking his life but was now being hounded by the police, because the attempt failed."

By and large the response to our cause has been encouraging. This is particularly so in the case of the medical profession, many of whom have in their own practice faced the "Doctor's Dilemma". Most doctors are humane, compassionate human beings and many of them share Dr. Christian Barnard's regret that they are not able to give relief from pain and distress to those of their patients in whose case they consider it appropriate. Hundreds of letters have been received by us, many of them extremely touching, about the sad stories they have to tell and the welcome they have given to our Society.

Our Society has prepared a draft Declaration and a draft Power of Attorney which it has issued to members for their use if they so desire. These documents make clear the wish of a man or woman in sound mind that, in case he or she is terminally ill and unable to give expression to his or her wishes, artificial medical treatment should be withdrawn and pain killing drugs given to him or her. The Power of Attorney would nominate two persons who would be duly authorised to persuade the doctor and family to respect the patient's wish if the occasion does arise. The Power of Attorney could of course be revoked at any time. Such documents are widely used in the U.S.A. and in U.K., where the law in regard to the abetment of suicide is the same as in India. These documents do not legally bind anyone but are valid documents even under the law as it stands today and would carry a great deal of moral influence.

Our Society is the 28th of its kind in the world. I was very happy to hear from my good friend, Arthur Koesler, the well-known writer, who said in his letter : "I am glad to hear that you are starting EXIT in India. It will be a long and hard way until charity and commonsense will do their work."

The *Examiner* a Catholic Journal, dealt with this matter in two issues. In its first issue of August 15, 1981, it naturally came out in opposition. I was glad to see, however, that in the second issue of August 20, 1981, the paper conceded that passive euthanasia may be justified. It quoted from the declaration on Euthanasia by the Congregation for the Doctrine of the Faith :

> "When inevitable death is imminent inspite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life so long as the normal care due to the sick person in similar cases is not interrupted".

The most common doubt that is expressed is the fear that any change in the law to make it more humane would make it easier for unscrupulous persons to bump off old and sick relatives. This is a genuine fear, but it relates to mercy killing with which we, as a Society, are not concerned, and not to Voluntary Euthanasia. The danger of 'bumping off' only arises when ore person can arrange for another person to die. It cannot arise when a man or woman in sound mind but terminally ill makes his or her own choice and asks for self-deliverance.

I believe that public opinion can be mobilised within the next few years when it has been made more aware of the issue. We in the Society believe in obeying the law, but we would like it to be amended so as to make it more humane and compassionate. ☐

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Family Planning–A National Priority Social, Ethical, Cultural and Medical Aspects

Role of the Medical Profession

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The medical profession over the ages acquired two major roles in society. The first the more ancient one of ministering to the sick and sorry. Of providing medication, treatment and relief for illness and injury.

The second role evolved later and gradually. It was that of a mentor to the society on health matters. It carried out this role by organising and instituting measures for the prevention of sickness. By advising and suggesting measures for the promotion of health. This second role less dramatic and less spectacular has not the glamour associated with the provision of relief from suffering. But it is perhaps more substantive and important as it promotes and preserves the weal, welfare and integrity of the society. The two roles however are not exclusive but mutually supplementary.

It is in the ambit of the second role that the medical profession's commitment is invoked to tackle the current population growth and the health hazards arising thereof.

Let us do a quick review of the estimated momentum of the population growth since the oneset of the modern era.

It took several thousand year of man's existence on this planet to reach the world figures of 500 million by A.D. 1650. It took the next 175 years by A.D. 1825 to double the population to 1,000 million (that is one billion). 105 years more to again double to 2,000 million or 2 billion) by A.D. 1930, and the next 45 years by A.D. 1975 to double again to 4,000 million (4 billion). At this tempo it is estimated that the world population by the year A.D. 2000 will increase to 7,000 million or 7 billion (Table 1)

TABLE 1

Year	*Doubling Time*	*Population*
A.D. 1650		500 million (½ billion)
A.D. 1825	175 years	1,000 million (1 billion)
A.D. 1930	105 years	2,000 million (2 billion)
A.D. 1975	45 years	4,000 million 4 billion)

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What are the penalties imposed on human existence and human health by this runaway population.

The first need of the people is that of food.

The problem is one of food and numbers. Can food production keep pace with the population pace.

The pattern of population expansion around the globe is not uniform. It ranges from zero growth to moderate in the affluent and developed countries. In the underdeveloped countries it is high. It seems that poorer the country the higher is the rate of its population growth. Resulting in the phenomenon that the countries least equipped to increase their food production are faced with high rise demand for food and nutrition.

It is estimated that two-thirds of the world's pre-school children suffer from one form or other of malnutrition. So does perhaps one-third of the world's population. Malnutrition may be one of low calorie intake or a more serious one of also low intake of proteins and other essential items. The resulting morbidity is of wide range.

A sensitive indicator of malnutrition in children is the slowing down of their growth and development. This may also be reflected in their later years by all round reduced capacity.

Infantile marasmus and kwashiorkar are not uncommon serious nutritional diseases. These are likely to occur when breast feeding is inadequate or terminates early due to one or another reason and the supplementary food given is deficient in calories and grossly so in proteins and other essential nutrients. These diseases have high mortality and are likely to leave permanent scars in the victims.

The classical nutritional diseases of beri-beri and pellagra are still quite common, Caused by deficiency of thiamine and niacin respectively in the diet and aggravated by protein deficiency, these may also leave permanent damages.

Anaemia is another wide-spread manifestation of nutritional deficiency occurring in all age groups. It is particularly harmful in mothers and children.

A number of other malnutrition morbidities like scurvy, rickets, goitre also occur but much less commonly.

Malnutrition directly contributes to lowered resistance to infections and inter-current diseases. The penalties on a nation from malnutrition are the decline in the general health of its population and the impairment of social and economic developments.

Let us look at our country. At the time of gaining our freedom our population was 350 million. Today it is nearing 800 million and by the year 2000 likely to cross 1000 million.

With 14 per cent of the world's population our geographical entity contains only 1.5 per cent of the world's arable land.

In the earlier post-independence years we had to import sizeable quantities of food. Today we are self-efficient. This is, however, a presucarious situation. Apart from the growing demand from an enlarging population, the vagaries of the weather and climate can tilt the balance.

Our increased food production was achieved by a combination of inputs. By use of fertilisers and pesticides, by improved variety of seeds, by better management of land and water resources, by application of new technology and energy resources.

There is however, a biological limit to what can be produced by these special essential inputs from the small layer of about 10 to 12 inches of top soil that covers the earth's crust. In some parts of the world this limit has already been exploited.

The population imposes another burden on the land. To meet the pressure of increasing needs and demands the processes of development cause diversion of land to other uses. Like for the expanding network of roadways and rail-tracks, for dams and canals, for the construction of buildings for habitation, for industries and other institutes. It thus cuts away land to that extent and diminishes it for food production.

Another problem that the population creates is of deforestation arising from the mindless cutting of trees to fulfil pressing needs. This causes erosion of the soil, ecological imbalance and leads to climatic changes. The sequalae of such disturbances are harish. An example of such consequences are the recent occurrence of prolonged drought and widespread famine in Ethiopia.

Poverty is a high breeder of ill-health. The poor denied the resources and services essential for positive health exist under adverse and insanitary conditions. Their resistance is reduced and they are easy prey to infections and diseases.

Poverty is compounded by unemployment. The unemployed parasitic are not productive. Both poverty and unemployment expand as the population grows rapidly.

In India the jobless today are estimated at about 50 million. Every month another 130,000 new entrants swell their cadres.

Man tends to pollute his surroundings. He does it more at his growing numbers crowd the earth. The environmental deterioration is aggravated by the increasing discharge of industrial effluents and toxic byproducts of technology onto the soil, the waterways and the atmosphere. The resultant environmental pollution has both direct and indirect effects deleterious to health.

The mounting pressure of high population growth imposes other penalties on the health of the people.

Man like other species requires a minimal space or elbow room in which he can function and lead a balanced existence. What may be labelled as his need of essential territorial exclusiveness. If the cordons of this territory are shrunk or intruded upon it causes his mental and physical disorientation and deterioration. Much of the social malaise and morbidity in the cities can be traced to the current fast trend of urban concentrations of high density.

The application of new health technologies in the developing countries has been comparatively facile. It has dramatically brought down their death rates. The professional cadres however have not been able to provide adequate level of individual health care in these regions. The doctor/population ratio there-in is low. So is that of the essential and supportive paraprofessional cadres. The fast population growth aggravates the deficiency. The training of these technical manpower groups is slow and time-consuming and their production cannot match the population pace. The demands for health services soon outrun the supply.

High fertility has a direct correlation with the health risks of women and children. In women besides causing a greater incidence of ill health associated with pregnancy and childbearing, it makes them more vulnerable to general health hazards and diseases. It reduces their reproductive efficiency and their capacity to give a good start and provide adequate maternal care and sustenance to their progeny. This is reflected in the occurrence of high fetal loss, more congenital malformations, low birth weights and raised infant mortality. The surviving children show more signs of malnutrition, impaired growth and retarded development. The adverse effects of high parity both in women and children are aggravated if the repeated pregnancies occur at short intervals. Uncontrolled and unregulated parity undoubtedly impose heavy penalties on women and their progeny.

High fertility rates are often associated with high rates of induced abortions. Often illegal and performed under most unsatisfactory conditions, these add to the health hazards of the women.

The communities which continue to have high birth rates show a profile of a young population and an age distribution of a pyramid with a wide base. In this pyramid O-14 years group forms a large cohort. The need of medical care for this group and the problems of its provision are more complex and difficult than for other age groups. This puts further pressure and strain on the medical network and its resources.

In cognition of the changing global pattern of human existence it is imperative that human fertility is controlled and regulated. The medical profession must take the prime responsibility to advise family planning as an essential health measure and propagate contraceptive practices.

Man stands apart from animal life. He is gifted with the power to think, to formulate, and pursue some enduring values. Amongst them is his capacity for compassion.

The raison d'etre of the medical profession is to demonstrate the quality of compassion in operation. It is in the compass of that aura that the profession functions to prevent *unnecessary deaths.* To the objectives of reducing pain and suffering. Not for financial rewards, not for economic gains. But in the fulfilment of the humanistic traditions that inspires the professional ethos.

The same altruistic grace should move the medical profession to commit its resources to prevent *unnecessary births* which but add to the sprawling numbers condemned to an existence of hunger, want and degradation.

The atom bomb is man's brain-child. The population bomb his biological child. Both a threat to this survival. The first threatening his dissolution in an instant flash. The second to a slower end by choking up and dissipation of the earth's resources essential for his existence.

Man must control both diabolic creations. In that effort the medical profession must be in the vanguard. □

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Ethical Dilemmas in a Health Policy Points to Ponder

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"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." This cardinal principle enshrined in the Constitution of the World Health Organization has been the guiding light for health planners and administrators the world over as they have attempted to steer their national health policies in the turbulent seas of want, hunger and disease.

How successful we have been in achieving this laudable goal, is, of course, a debatable matter. What, however, is beyond any doubt is the fact that for vast number of people in the world, health remains an illusion, a dream.

What makes the problem more complex is that in an age of conflicting demands and limited resources, health unfortunately takes very low priority. The experience usually has been that when budgetary cuts become inevitable, the axe falls first on the health sector.

It is largely for the above mentioned reasons that we find ourselves in a situation where hundreds of millions of people in rural communities in the developing world have little or no access to health care. On the other hand, "disease palaces," as the Director-General of the World Health Organization, Dr. Halfdan Mahler, once described some ultra-modern hospitals, consume a sizeable portion of the country's health budget. We therefore find ourselves in the uneviable position of spending 80% of health budgets on 20% of the population, whereas 80% of the population living in rural areas has to make do with 20% of the budgetary allocations. If ever there was an ethical dilemma, this is it.

So, what does one do about it ? How can there be a more equitable distribution of available health resources ? How can the people be equipped to take care of themselves ? All these questions, and many more, have been raised in the past few years in international conferences as it has become increasingly obvious that in order to achieve a reasonable standard of health, the people themselves will have to do something about it.

Health for All

The beginning of this direction was made nearly a decade ago when, at the World Health Assembly held in 1977, the Member Countries of WHO adopted the historic resolution setting for themselves the goal of "Health for All by the year 200." The following year, WHO and UNICEF organized the first-ever international conference on Primary Health Care at Alma-Ata, USSR. It was here that the vehicle through which health for all could be achieved, primary health care, was identified. Since then the momentum has grown with countries formulating their national strategies and plans of action to achieve the goal. Also, as a result of public debate on the issue, health has been recognized as an integral part of the development process. In fact, it is now acknowledged that without health there can be no development. What has also emerged recently is the understanding that health is not the responsibility of the health sector alone, and that in order to achieve common objectives, health development needs to be a multisectoral effort.

It is, for example, now an accepted fact that health depends on a number of supportive services, like health education, nutrition, water and sanitation, just to name a few. This aspect, of health development encompassing many disciplines was most forcefully emphasized in the Declaration of Alma-Ata. In spelling out what was meant by primary health care, the Declaration stated that this included at least: education concerning prevailing health problems and the methods of preventing and controlling them: promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

If one examines these eight elements separately, it becomes obvious that in order to make primary health care available to all would mean active collaboration and coordination between various departments and ministries.

Policy-making Problems and Pressures

In order to make any objective assessments or set realistic targets, it is necessary to keep in mind that health development has to be viewed in the context of the prevailing socio-economic conditions. For example, it is impossible to expect any dramatic improvements in the health status of the people without a corresponding improvement in the agricultural or industrial production, literacy rates, status of women, and so on. I am purposely not going into the area of health statistics, of demographic profiles or disease patterns, because I wish only to differ some trigger points for discussion.

What is important to bear in mind is that many developing countries like ours find themselves in a very real predicament. The predicament of choice. Not because there are several choices, but because there are very few. Thus we find that while on the one hand there are millions without adequate medical care, on the other hand there are thousands of qualified doctors with nothing to do. Thus we find that whereas production of drugs is adequate, it never reaches the places it is most needed. Thus we find that simple, low-cost technologies that are available and acceptable to the people are not utilized. Here, it is not so much a matter of inadequate knowledge as the inability to take the necessary decisions at the policy-making levels. It is here that political commitment assumes a very significant role. For without such commitment, most ideas never get translated into action.

Community Involvement

Largely as a result of the movement set in motion by the resolution setting the goal of health for all and the subsequent actions taken at the country level, it is now realized that without the involvement of the community the goal of health for all can never be achieved. An active and self-reliant people can do a lot for their own health and the health of their fellow beings as well as prevent, control and treat diseases. But the real question that needs to be answered is how far do countries want their people to be self-reliant. This is not merely a rhetorical question, it has serious political undertones.

Even if one chooses to stay clear of political issues there is no denying the fact that many factors having a direct bearing on health are largely influenced by political decisions. To give just one example, one could cite the per capita expenditure on health. In most developing countries it can safely be said that expenditure on health is perhaps the lowest, compared to the other sectors. Here one need not draw comparisons between what is spent on defence, as compared to health. But the example is important to keep in mind because of its bearing on policy-making.

Another example in this context is the success achieved in some developing countries with regard to the provision and training of community health workers and the steps taken to rationalize the production and usage of drugs. Though the experience with community health workers has varied from country to country, the question of essential drugs has been most interesting. After WHO came out with the list of 200 essential drugs which an Expert Committee had recommended for use in primary health care, several countries set about to further refine the list. This was a political decision, taken at the highest levels as it very directly affected the interests of the multinational drug companies. But, here again, once the policy makers were convinced of the merits of the case, they were willing to take the decisions even though it meant going against well entrenched vested interests.

Similarly, once a country sets for itself the goal of health for all, the operative word becomes *all*. And when a country decides that the way it will achieve that goal is through primary health care and community involvement, then it also means that the country is prepared to take care of the consequent increased demands that will be made on existing health services.

As any one connected with the health services knows, it is one thing to create the right awareness and motivate the people to become self-reliant in health care, and quite another to cope with the demands. More damage is done to the credibility of a service if, having generated the demand, the health services finds itself incapable of coping. That is why it is essential to develop the necessary infrastructure before creating a demand.

These are all factors that have to be carefully examined, keeping in mind the special needs of the community. In a country as vast and diverse in its culture as India, no blanket norms can be applied to any situation. It requires inputs tailor-made to specific needs. And herein lies the biggest challenge, as well as the opportunity to provide the people with the basics in health care. It is only then that the cherished goal of health for all will be achieved. ☐

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Population Explosion and Health Policy— Ethics and Huamn Values

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The great importance of population explosion in the formulation of health policy is recognised by nearly all countries all over the world. The developing countries, however, consider it of paramount importance. While the highly developed countries have become somewhat lukewarm over this problem because they have controlled their populations and their people are well educated and have attained a high standard of living—the two important measures for the control of population—the need of such control for the developing countries and perhaps, most of all for India, because of its vast population is extremely urgent.

Before dealing with the subject of my address I may quote the definition of the three terms used for the main theme of the Conference.

Dr. Edmund Pellegrino defined as follows the three items, during his key-note address at a similar Conference in Athens.

—The health policy of a nation or a community is its strategy for controlling and optimizing the social uses of its medical knowledge and resources.

—Human values are the guides and justifications people use for choosing the goals priorities and means that make up that strategy.

—Ethics act as the bridge between health policy and values. Ethics examines the moral validity of the choices that must be made and seeks to resolve conflicts between values, which inevitably occur in making those choices.[1a]

One of the important factors that determines health policy, therefore, is to find out what the basic cultural, ideological, ethical and religious traditions of a nation are, and how they can be harmonised with the health needs of the nation.[1b]

Family planning which is essential for controlling population explosion, however, presents one unusual feature. While its urgent need is acknowledged almost universally, when we go into its methodologies and the choice of such methodologies—there is hardly any method which does not evoke controversy. Such controversies are based mostly on ethical, cultural and religious factors and human values which naturally show some differences in different nations and various communities. in the same nation. Legal views and laws on such matters which I think, are predominantly based on ethics and human values, also differ, to some extent in different countries. Some objections of course are based on medical grounds. It is somewhat strange that while the importance of family planning is acknowledged universally, no other subject which enjoys such universal acceptance as a basic idea evokes greater conflict with ethics and human values than family planning when you go into the details of its working.

The urgent need of family planning needs no emphasis. In India it should be regarded as number 1 national problem for unless we attain success in our population control methods, all our planning and other efforts for improving the economic condition of the population of our country and improving the lot of poverty stricken millions the majority of whom are in a state of malnutrition and for achieving the goal of "Health for All" by the year 2000 AD will go away and may practically come to nothing. Our Government is spending millions on what they call family welfare, but the question that arises in the minds of those who are unprejudiced and are willing to listen to the calculations of those who are trained in such problems, is—are our efforts showing signs of success and are they likely to bear fruit in time before the situation attains dimensions that will defy all solutions ?

The birth rate in India in 1984 was 33.8 per thousand and the death rate 12.5 per thousand. The population growth rate is thus near about 2 per cent. This means that we are adding every year 16 million human beings to our population. This according to most demographers will mean that by the year 2000 AD a year by which we are committed to "Health for All", we will have a population nearing the mark of 1 billion. It is incomprehensible that we can provide health for all if the population by that year attains as high a level as stated above. There is another adverse effect of this state of affairs that I may point out. Most demographers point out that a big portion of this population, unlike that in developed countries, where birth-rate is controlled but longevity has gone up, will be of younger people of marriageable age. The result of this inbuilt demographic momentum is that even if present family planning efforts succeed to reduce the growth rate to one per cent by the century end, the population will eventually stabilise in 2050 at 1250 millions. A delay of 20 years in reducing the growth rate to one per cent will accelerate the stabilised figure to 1.9 billions and of another 20 to 2.6 billion.

To give an idea of the strains placed on the economy by unhandled population growth let us see what the impact of the 136 million population added during the seventies decade will mean. The Ministry of Health in a very modest calculation that placed the direct cost of maintaining the additional population at an average income level of 1000 per year has given the estimate of Rs. 13,500 crores as the additional annual requirement to cope with this decade's increase alone. It has been estimated that an additional resource requirement of 11,850,000 quintals of food, 180,000,000 metres of cloth, 121,000 schools, 355,000 teachers, 2,3[illegible],000 homes and 3.8 million jobs for the seventies explosion. Now through the eighties an annual 16 million is being added as opposed to the 14 million annual average of the seventies.[1]

Since 1974, the global population growth rate has declined from 2.03

to 1.67 per cent per year. In the next decade the growth rate will decline more slowly. However, the annual increase in numbers is expected to continue and may reach 90 million per year by the year 2000. Ninety per cent of that increase will occur in developing countries and at that time 6.1 billion people are expected to inhabit the earth[2].

When we come to the various methods employed for family planning, there is a big range already available, though in a country, like India, efforts are still going on so far as the research field is concerned to find a method which may have the widest possible acceptance and may be free of risk and highly efficacious. So far as the available methods of reasonably proved efficacy are concerned at one extreme is abstinence and at the other extreme is medical termination of pregnancy (M.T.P.). Abstinence, of course, can have no moral or ethical objections. It had the support of saintly personalities like Mahatma Gandhi. In fact, even some religious group[3] and their leaders which on religious grounds are fundamentally against all artificial means of family planning are not against it by what is called natural methods. Some of them have tried to find its modifications like the rhythm method which has been improved lately by finding the mucus secretion of cervix which precedes ovulation and which the woman can be taught to find for herself, and which thus indicates to her the day of ovulation. However, while such methods may have some practicability amongst the well educated, closely knit religious communities, it cannot have much utility for checking the population explosion so far as the vast mass of 750 millions (out of which 127 million couples are in the reproductive age period), are concerned. In fact, a further improvement may occur in this method, i.e., science may very soon reveal a method by which the actual day of ovulation may be found out by simple tests, yet even then human nature and instincts as they are it will not make this method feasible so far as the control of population explosion is concerned. So, while some communities and religious groups and their leaders are still advocating it, we may not discuss it further in a limited address.

The methods of family planning and contraception are so numerous that I cannot discuss the ethical and human values of all of them, but I may select three items which have evoked or are likely to evoke the maximum controversy on grounds of ethical and human values and their interconnected legal aspects. They are : (1) Enforcement of a policy of limited number of children by various types of legislative measures, (2) voluntary sterilisation and (3) M.T.P. (Medical Termination of Pregnancy).

China by launching a one-child policy claims to have achieved a spectacular success in their family planning programmes and restriction of population growth. Some independent observers have confirmed this claim. Though India was the first country to adopt family planning as an official programme and can claim some reduction in birth-rate, its population growth is still maintaining an alarming tempo. Can we, as also the other democratic developing countries of the world, achieve success in time to limit our population to such a level that it will not affect our economic growth and other programmes for prosperity and removal of poverty ? This raises a highly ethical and legal question for a conference like this. In such democratic countries, especially in India, the rights of an individual reign supreme. They cannot be interfered with except to a limited extent in the event of a war or threat to national security, even though as is evident from the details that I have given above, the issue of family planning upon which future prosperity and stability of the country depends is of no less importance than the destruction caused by an actual war. However, unlike wars—speaking in medical terms it is not a question of sudden death but a lingering existence of starvation and malnutrition for millions. All the same a question arises, "Can any democratic Government impose its will and order that no family can have more than two children and impose penalties if this rule is violated ?" If we find at some stage that our present developmental schemes and plans are not bearing fruit and the deluge in population seems to destroy all hopes of health, prosperity and well-being of our future generations, can we have legislation in which the state in this particular matter of number of children in a family impose its will on the people ?" This would actually mean that because of an emergency we make the rights of an state or the nation as a whole supersede the rights of an individual. Individual human values and rights in practice if not in a written law include right freely to choose the time of marriage (subject to legal minimal ages); the right to decide on the number and spacing of children in the family (the right to contraception) and to decide about one's own body in relation to this (sterilisation and abortion, within existing legal constraints)[4].

As an alternative to the above type of legislation which would be repugnant to principle of human rights, can the great legal experts make some other suggestion which *may make people limit their* families and thus ensures progress and prosperity.

Let us, however, hope that the contingency for enacting the above type of legislation or some similar action will not arise. In facts, at the 1984 United Nations International Conference on Population in Mexico City there was still some difference of opinion amongst nations over future policies. For example, while the Vice President of Kenya told the meeting that the world "cannot wait for the crisis of over-population to right itself through economic development" the United States delegation presented an opposing view and gave examples of Hong Kong and South Korea which though had scarce natural resources had made swift progress by relying on the creativity of private individuals working within a free economy. However, the consensus amongst nations was that family planning is needed to supplement the effort of economic development in reducing population growth, and almost all developed and developing countries endorsed at the Mexico City Conference, family planning as an integral part of development, and acknowledged its contribution to the health of women and children[5].

How difficult the question of family planning is and how it is almost impossible to meet the social objections to it which will very from country to country according to their own cultures and traditions will become apparent if one goes through some of the recommendations on family planning at the Mexico City International Conference on Population held in 1984.

Recommendation 25

Governments should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of *children.* Family Planning information, education, and means should include all medically approved and appropriate methods of family planning *including natural family planning, to ensure a voluntary and free choice in accordance with* changing individual and cultural values. Particular attention should be given to those segments of the population which are most vulnerable and difficult to reach.

Recommendation 30

Governments are urged to ensure that all couples and individuals have the basic right *to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so*; couples and individuals in the exercise of this right should take into account the needs of their living and future children and their responsibilities towards the community.

Recommendation 31

Legislation and policies concerning the family and programmes of incentives and disincentives *should be neither coercive nor discriminatory and should be consistent with internationally recognised human rights* as well as with changing individual and cultural values.

Recommendation 33

Governments that have adopted or intend to adopt fertility policies are urged to set their own quantitative targets in this area. Countries implementing family planning programmes should establish programme targets at the operational level, *respecting the basic right of couples and individuals to decide freely and responsibly the number and spacing of their children, taking into* account the needs of their living and future children and their responsibilities, *exercised freely and without coercion, towards the community.*[6]

You can see how carefully these recommendations are worded and how carefully that organisation has avoided objections from any country on social and ethical grounds. For various countries according to their own culture may have their own objections. They are giving in every one of these paragraphs precedence to human rights. But will developing countries attain appreciable success under these conditions.

It is, apparent that while a vast number of countries especially the developing ones are in favour of family planning, there are objections on social, human, ethical and legal grounds from Nations and communities in the same nation and every question concerning the family planning becomes a complex one. It is for the various learned speakers who will be taking up various aspects of this subject to throw light on some of the points that I have raised.

The next item that I may take up is of voluntary sterilisation. In the beginning there was a lot of opposition to it in many of the well developed countries on certain moral grounds, as the opponents said that it amounts to mutilation of the human body either in the man or the woman, i.e., vasectomy in males and tubectomy in females. Moreover, there was opposition to it because it is irreversible. It is in fact the main method of irreversible nature—though scientists and surgeons are making efforts to make the two methods one in males and one in females reversible. Tubectomy is being done extensively now through the endoscope (laproscope). The fact that now tubectomies are being undertaken far more commonly than vasectomies, though the latter is a much easier operation almost free from risks only shows the continuing domination of man over woman which still persists in most countries.

These irreversible operations are open to one great objection and that is that why should they be resorted to when reversible methods are easily available, for if the existing off-springs die due to unforeseen circumstances the parents become issueless for ever. So, interconnected with the successes of these operations must be a sustained effort to diminish infant mortality. In developed countries where reversible methods can be easily followed by well educated couples, these irreversible methods are no longer favourites. However, in countries like India where millions and millions of couples in the reproductive age period exist and cannot be relied upon to use consistently the reversible methods, these irreversible methods have remained the most favourite with administrations. In India it is the most favourite method with the state governments. This is especially so because it ensures certainty of results. It is so far done after there have been two children unless the parents themselves volunteer to get it done earlier. Many state governments expect some sort of targets from their doctors though they may not do it openly.

In many of the well developed countries there have been long controversies over whether voluntary sterilisation (they never even dream of forcible sterilisation) should be allowed at all or not. In some countries, it is still illegal, but generally speaking in most countries a liberal view is being taken and voluntary sterilisations are either being allowed by law or at any rate being overlooked, and no prosecutions are done. In India, however, voluntary sterilisation as I have said is favoured, but there is a strong public opinion against forcible sterilisation which a democratic country like India will never allow whatever the needs of the country may be. This raises, in fact, again the question of individual rights versus the right of the State to impose its will. However, we should avoid reaching that stage.

The guidelines protecting voluntarism and ensuring safety should, however, take priority over more administrative matters.

The most pressing ethical and legal issue today is how to ensure that sterilisation is 'voluntary' in the sense that the decision to be sterilised is one which is informed and unpressurised. (7)

As regards the reversible methods, the main difficulty is whether they are acceptable and most easily available to our masses of rural population, quite a lot of whom are not educated enough to understand the utility and proper applicability of these methods. Out of these methods, the main controversy lies as regards MTP and certain ramifications of this method which I will mention later.

For the sake of avoiding unnecessary objections, it has now been termed Medical Termination of Pregnancy (MTP) and the word abortion is hardly ever used. Feelings in certain countries are so strong on this question that in the last International Population Conference in Mexico, USA made the banning of abortion as a measure of population control a central condition for its population assistance. Moreover, laws for termination of pregnancy raise another ethical question—'has a foetus a personality'. If it has a personality, it naturally has rights.

According to the latest Indian law on medical termination of pregnancy, such termination has been made permissible under certain conditions. The Indian law was enacted in 1971 to protect the women's rights, if there was a fear that future physical or mental health of a woman is imperilled if pregnancy continues. In this connection one out of the various clauses that allow termination may be quoted :—

1. If the continuance of the pregnancy would involve a risk to the life of the pregnant women or of grave injury to her physical or mental health.

Inclusion of mental health, in fact, makes the attitude of law towards termination quite liberal but reasonable, for any unwanted pregnancy is going to have psychological effects on the mother. Explanation of the above clause states :

> "Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant women."

This explanation makes the permission liberal indeed and almost any case who has been making attempts to use cuntraceptives can come under it.

Though the above law was enacted for a different purpose, it must be conceded that indirectly it may help population control, as a sizeable number of patients in whom contraception fails will in all sincerity take recourse to it. However, it must be acknowledged that MTP as a means of population control means a failure of contraception either due to carelessness or due to chance or due to ignorance. We must, however, see the other side of the picture, also. If it is not made permissible under the law, the acts of termination will go into the heads of the unqualified persons which means a very high increase in complications and even fatalities. Such cases have been quite frequent in many countries including India. That in itself is a big justification for evolving the present law on medical termination of pregnancy. In fact, in the short run it has been said that a desire for effective contraception also leads to an increase in abortions. Because of this inter-ralationship, contraceptive and abortion services need to be linked.[8]

I think there will be no difference of opinion as regards the necessity of MTP when the future physical health or the life of the mother is in danger for you have to save one of the two lives and the mother's life is no doubt more valuable of the two. Even the most conservative and religious minded persons will not contest it. However, considerable differences of opinion arise when we consider the mental health and future psychological state as a result of an unwanted pregnancy. For a doctor, however, future mental health is as important as physical health. However, such a justification does give considerable handle for malpractices.

The opposition to MTP as a means of population control is, however, understandable. When other effective methods of family planning are available, why should we destroy a life just because a couple has been negligent and did not practise the method properly. So, they argue on ethical grounds that induced abortion should not be included as a method of population control especially as it destroys a life which legally speaking has a personality of its own and we have thus, no right to destroy it. However, the protagonists of MTP who want it to be included as a plan in family planning argue that as no contraceptive method is infallible, an unwanted pregnancy should be terminated and, so, I understand certain countries are very liberal about MTP. They further argue that the population control for developing countries is a national need which should be treated as an emergency and must supersede all other considerations. Moreover, when laws to prevent induced abortions are made more strict it only leads to the emergence of quacks and secret abortions which increase manifold the risks to the health and life of the mother. Thus, on this ticklish question of MTP which involves moral values and religious and ethical beliefs a consensus of medical and legal opinion is needed as to how liberal the legislation should be to allow MTP as a legitimate method of family planning without leading to immorality and sexual promiscuity, especially at the level of very young age groups. As I have said above, if it is not liberalised it only leads to abuses and going to quacks. The major problem, therefore as regards moral and legal issues involved in MTP is one of proper implementation.

All that I have said above, of course, does not obscure the fact that the debate over abortion, even in countries where the law has been reformed, is a passionate one.[9]

A few related questions may be discussed at this stage. With the advances in medical sciences, especially ultra-sound examination and amniocentesis, it is possible in some cases to see if the future child is going to have physical or mental abnormality. What should be the criteria of judging which deformity or abnormality, physical or mental, is going to be so serious that termination of pregnancy is justified. Divergences of opinion are bound to occur. But it is for medical men and social workers to devise criteria for allowing MTP in such cases. However, a more serious problem is arising in this country and may be in some other countries. It has become possible by the above methods to find out the sex of the future child. As a theoretical or purely scientific exercise it is interesting but the knowledge of that to parents is likely to be used for one purpose, especially in families which have a preponderance of female offsprings. They will utilise the knowledge for secret termination of pregnancy if the foetus is found to be a future female child. This means in a way reverting to the age old highly unethical practice long since prohibited by law of female infanticide. Rather than to take this risk, will it not be better to prohibit by law the emergence of laboratories which reveal this knowledge to the parents in early stages of pregnancy.

If induced abortion is to be considered strictly from the moral and religious angle then certain reversible methods may actually be leading to the induction of abortion but are not being categorised as such. For example, MR (Menstrual Regulation) by protaglandins or by an MR syringe is certainly an abortion in a vast majority of cases. Should it be allowed even though foetal life at that stage is very early and almost invisible. Use of certain drugs may possibly be also an abortion of the foetus at a very early and almost invisible stage. If a vaccine against protein carriers of vitamins to the foetus becomes successful that will also be abortion at a very early stage of the foetus—only killing it before it become even recognisable as a foetus. So, if religious and ethical and moral considerations prevail there will be objection to such methods also which are ordinarily regarded as methods of contraception but are really abortions at a very early stage before the foetus becomes even anatomically visible to the naked eye.

There are many reversible methods of contraception such as condoms, pills, insertion of copper T etc., long acting injectables, some herbal medicines such as gassypol—a Chinese herbal medicine for males—and coitus interruptus. There are not likely to be any ethical objections to such methods except by the most conservative and religious groups who do not want any interference of the natural process, but there can be objections to all such methods on health grounds or on grounds of inadequate acceptability. We need not discuss that.

An associated question is the question of incentives and disincentives. There have been not discussions on this question. However, the main objection which involves ethical values as regards some incentives and nearly all disincentives is that why should a third or a fourth child suffer from certain handicaps in comparison to other children who may be even less bright than him/her, because his/her parents made the mistake of not falling in line with a policy which was very important from the national point of view. Why should the sins of parents be visited on off-springs. His/her parents may deserve those handicaps but why should the child suffer who committed no fault? It is an important objection from the ethical point of view and, so, there should be no question of disincentives, thought some incentives may be chosen carefully and may help to some extent in carrying on the family planning programme specially in certain limited circles like industries etc.

There are two other issues which I cannot/take up in detail, but which are worth mentioning. *One is reducing the infant mortality.* In India it is still shamefully high. It is higher than that of many developing countries and was 104 per thousand live births in 1984. It is generally admitted that family planning is acceptable only if the infant mortality is low and most children which are born have the prospect of living a normal life. The Family Planning Foundation is in the process of investigating in collaboration with the International Development Research Centre (IDRC), Ottawa, Canada, *whether such a statement is a fact or not so far as Indian* *conditions are concerned*, and also find out the high risk factors associated with infant mortality in various areas so that the Government may be helped to mount an intervention strategy. There can obviously be no ethical or human objections to it and the lowering of infant mortality will be welcome to all communities. *The second important factor which promotes family planning is* raising the status of women. For quite a number of extra births take place because the parents want a male child. Moreover, a woman seems to have in this country only a small place in deciding the number of children that she should have. The need of raising the status of women is still felt even in the most developed countries for the opportunities for all types of employment are still less for women than what are available to males. Governments should formulate and implement concrete policies which would enhance and raise the status of women.[10]

It is a proven fact that in development countries that to the extent to which legislation ensures full and free access for women to education and to employment on terms and conditions of complete equality with men, the effect will be to reduce fertility.[11]

An important point in this connection is raising the age of marriage of the girls. If that age could be raised from 18 to 21, and sterilisation could be induced as far as possible after the age of 30 there will be a very shary fall in the number of births. According to demographers, nearly half of the births occur before the age of 20 and after the age of 30. There can be no ethical objections to raising the age of marriage in girls if it is done on the grounds of improving or saving the health of the young girls. However, legislation for this purpose is not likely to succeed and will have ethical and moral objections in addition. It means an interference with human rights of the individual.

It must be realised that there is no method of contraception which can have no objections, is absolutely safe and is fully efficacious and universally acceptable. That is why research is going on and on to find a most acceptable, most efficacious and most harmless method. However, the problem is so urgent that we cannot wait for the results of such research. Even when there are some minor objections and flaws on grounds of health and efficacy, we have to look at such problems from a different angle, i.e., greatest good of the greatest number and the acute need of the nation. So occasional small risks have to be taken.

The doctors are, of course, needed for the execution of the various methods and are key-figures in teaching the public the various techniques etc. However, they have one greater role to play and that is to mould public opinion in favour of family planning. Doctors alone cannot achieve success in family planning. If we want great results, family planning has to become a people's programme. Thus, it is necessary to develop extensively public opinion in/its favour especially at the grassroot level. The doctors come in close touch with the family and the general practitioner who is a family physician and almost a family member for most families can thus be a great factor in developing proper public opinion in favour of our family planning programme. It must be realised by all of us that family planning which may be technical easy is socially difficult and doctors can be a great factor in overcoming that social difficulty. Non-government Voluntary Organisations can also play a very great role in this direction. In fact, that should be their chief role in addition to helping the government in their programmes. Let us hope the combined efforts of the government, the medical profession and the non-goverment organisations like the Family Planning Foundation achieve significant success in the Seventh Plan so that we may succeed in our health for all programmes by the stipulated year 2000 A.D. and enter the next century in a prosperous and hopeful vein. ☐

References

1A. Edmund & Pellegrino. Key Note address at Health Policy—Ethics & Human Values Conference at Athens in 1984. Published in Highlights of Athens Conference—XVIII CIOMS, Round Table Conference, Athens 1984. Edited by John H. Bryant and Zhijniew Bankowski 1986. page 7,

1B. Robert Veatch. Some as abovel. Page 11.

1. Address by Shri B. Shankaranand, Minister of Health and Family Welfare, Government of India, at the Conference of Voluntary Organizations on Promotion of Family Welfare Prgramme.

2. Mexico City Declaration on Population and Development.

3. Ganguli, H.C. Sexual Behaviour : A New Perspective in Family planning—Publication of the Department of Psychology, University of Delhi, 1984, pages 18 and 109.

4. Law and Fertility in Europe edited by Maurice Kirk et al—Publication of the European Centre for Research and Documentaion in Social Sciences and International Union for Scientific Study of Population—1975—Preface page II.

5. Malcom Potts—Population and Politics (leading article) BMJ 1984, 289—641.

6. Ibid.

7. Law and Planned Parenthood—Edited by John Paxman for International Planned Parenthood Federation—1980, pages 38 and 59.

8. Ibid.

9. Ibid.

10. Mexico City Declaration on Population and Development.

11. Trevici, V. Law and Social Status of women—Law and Fertility in Europe (same as 4) 1975—page 97.

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INTERNATIONAL CONFERENCE
HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Ethical and Legal Aspects of Family Planning

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I deem it a great privilege to have been asked to address this session of International Conference on Health Policy—Ethics and Human Values. The topic for this session is family planning—a National Priority. I would be speaking to you on the ethical and legal aspects.

It was 36 years ago that India became a republic and The Constitution of India came into force to secure, *inter alia*, to all its citizens social justice and dignity of individual. Part IV of the Constitution contains directive principles of state policy, which as mentioned in Art. 37 were fundamental in the governance of the country and were to be applicable, as duty of the state, in making laws, clause (f) of Art. 39 Contained in that part provided that. The state shall direct its policy towards securing that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity. According to Art. 47 the state shall regard raising of the level of nutrition and standard of living of its people and the improvement of public health as amongst its primary duties. These were great objectives, earnesty conceived and nobly worded, but even though a period of more than three and half decades has passed since then, the goals visualised by the founding fathers in these articles have remained elusive and more or less a tantalising illusion. Not that efforts have not been made towards attainment of those objectives. We have had a series of five year plans conceived primarily to bring about economic regeneration. We have had earnest. well-meaning persons who have striven in their own way and as best as they could to banish poverty and raise the living standards. We have made considerable headway in industry and technology as also in agricultural, dairy and poultry production. We have built dams and initiated river valley projects. We have spread network of roads and provided for Quick means of transport. We have also established a large number of educational institutions. But despite all these efforts, we still continue to be steeped in poverty and backwardness and our average standard of living is one of the lowest in the entire world with one of the lowest per capita income. If one were asked as to which has been the chief culprit and the main cause for frustrating and setting at naught all these efforts to raise the economic level of the people, the finger must pin-point in the direction of population explosion. The increase in population during the last four decades has upset all plans and frustrated all efforts to bring about betterment and amelioration in the living standards of the people. India's total population touched figure of 685 millions in the census of 1981. This represents an increase of 25% since 1971 when the population was 548 millions. It would be pertinent in this context to mention that India's population which was 238 millions in 1901 increased to 361 millions in

1951 and to 685 millions in 1981. Thus in the first half of the present century, i.e. during the years 1901—1951 India's population increased by about 51.5% whereas in the next 30 years from 1951 to 1981 it increased by 89.8%. The main cause of this increase can be attributed to fall in the death rate due to better health conditions and more efficient handling of epidemics. A sample survey revealed that the birth-rate in 1980 was 33.3% and the death rate was 12.4. The expectation is that the death rate would decline still further and be brought down to 10 per thousand by 1990.

The increase in world population during the year 1985 was 85 millions bringing it to a total of 4.9 billions. The population growth rate declined from 2% in 1970 to 1.7% in 1985. Even at this rate world population is expected to be 5 billions by middle of 1987 and 6 billions by the end of the century.

Unless therefore we can devise some measures to control the population growth, we can take it that all our plans for raising the living standards would go away and run into rough weather and the problem of poverty, backwardness and low living standards would haunt us and dog our steps for years to come. As it is the average increase per year of the population of India is more than the total population of Australia. It is in this context that the question of birth control has assumed tremendous importance,

So far as the ethical aspect is concerned I would say that it is inherently immoral to give birth to children if we cannot secure for them proper food, clothing and shelter and provide them with requisite education to grow into healthy, self-reliant adult-hood with prospects of decent standard of living. At the same time it would be unrealistic and plainly discriminatory to deny to the poor sections of the community the incident and satisfaction of a normal marital life. Begetting of children and the continuance of the family line is as such an important objective and desideratum of married life amongst the poor as amongst the affluent sections of the community. The difficulty, however, arises because the growth rate of family members amongst the poorer sections was and continues to be at a level higher than that of affluent sections who as a result of education have realised the desirability of restricting the number of children. It is in this context that some action is called for and some measures need to be adopted to bring about a state of small families in regard to poorer section of the community.

At the same time we have to bear in mind that in view of the consequences of resort to compulsory methods during the period of emergency the government would be reluctant to enforce compulsive measures. Faced with this situation all that we can do is to build a strong public opinion and create a General awareness of the need for and desirability of a small family. It has to be impressed upon every one that small family is a desideratum not merely because of any altruistic consideration or as a part of obligation to the society but much more than that as a matter of sheet enlightened self-interest of the individual concerned and for the benefit and welfare of his own children. Human nature being what it is, experience tells us that enlightened self interest is a much more potent motivating factor for an average person.

Coming to the legal aspect I may say that law does not prevent or impose a ban upon the procreation of children beyond a particular limit. Law, as was once said by trudeau, has no function in the bed-room of the married couple. Indeed attempt by law to impose restrictions upon the number of children might well be construed as an intrusion into the privacy of individuals' married life. At the same time law can provide incentives to couples to restrict the number of children. Such a law has been enacted in number of countries and it is a perfectly valid piece of legislation.

India adopted family planning as official programme in 1958 as it recognised that a timely check on population growth would in turn raise the living standards of the people. During the period of the first two plans from 1951 to 1961 the emphasis was mainly on research in the field of motivation, communication, demography, physiology of reproduction and extension of organisations for providing clinical services. Since then various ideas have been set afloat. The objective of family welfare in 1978 was to reduce the birth rate to 30 per thousand of population by the end of 1982-83 from the existing 33 per thousand population. At present the demographic goal is that the average woman should be replaced by one daughter and two child family as the normative pattern and to attain this objective by 1996.

Although section 312 which makes it an offence and provides for punishment for causing miscarriage, unless it be for the purpose of saving the life of a woman, still continues to be a part of our panel code, the parliament enacted in 1971 the medical termination of pregnancy Act. According to this act notwithstanding anything contained in the Indian penal code, A Registered Medical Practitioner shall not be guilty of any offence if any pregnancy of length not exceeding 12 weeks in terminated by him or where the length or pregnancy exceeds 12 weeks but does not exceed 20 weeks if two registered medical practitioners are of opinion formed in good faith that the continuance of the pregnancy would involve risk to the life of the pregnant woman or of grave injury to her physical or mental health. Likewise the law relating to abortion has been liberalised in other countries. In England notable part in this direction was played by Mrs. Margaret Sanger, while in the United States three connecticut women, one of whom was Mrs. Katharine Houghton Hepburn, mother of the famous Actress Katharine Hepburn, made significant contribution in starting birth control leagues. Some of the most interesting cases relating to birth control and abortion were decided by us Supreme Court. One of such cases, was Poe vs Ullman decided in 1961. In this case law relating to ban on clinics for birth control was challenged. The Supreme Court, however, turned down the request. Justice frankfurter who wrote the majority opinion said that the issue related to a dead letter and the court could not be umpire to debates concerning harmless empty shadows. According to him the fear of enforcement of that law was chimerical or imaginary because provisions of the law had gone unenforced. Justice Douglas who wrote the minority Judgement in a Scathing Criticism of the Majority view observed:

> "What are these people—Doctor and Patients— to do? Flout the law and go to prison? Violate the law surreptitiously and hope they will not get caught? . . . It is not a choice they need have under. . . our constitutional system."

Soon thereafter clinics started openly working in connecticut. A complaint was then filed and the Supreme Court was forced to decide this issue in 1965 in the case of griswold. This time Justice Douglas was on the side of the majority. The majority held that the impugned law trespassed into the zone of marital privacy, a realm of family life which the state cannot enter without substantial justification. The law was accordingly struck down. In a subsequent judgement in 1972 the Supreme Court extended the above principle to the case of single individuals. Ultimately in a decision given in 1973 in Poe's case the Supreme Court held that the right of abortion was not absolute and added a restriction. All abortions, the Court held, were not legal. A formula was evolved, according to which in the first three months of pregnancy the right of privacy prevails and the abortion decision was upto the woman and her doctor. During the second period of three months the state could regulate abortion in a way related to maternal health. In other words the state could require that operation be performed under certain conditions. During the last stage of pregnancy the court held the state laws could prohibit abortion except under circumstances in which the life or health of the mother was in danger.

One might discern a note of similarity between the view taken by the the U.S. Supreme Court and that which had been taken earlier in the law passed by The Indian Parliament in 1971.

Friends, I have been talking to you about the ethical and legal aspects of family planning, restricting the number of children and about the permissible limits of resorting to abortion. It would, however, be wrong to think that the matter has only ethical and legal aspects. More than anything else it is human problems and relates to some of the most intimate aspects of human life. This apart the issue has a vital bearing on the social equilibrium which is bound to get upset and disturbed by further increase in economic disparities. Unless we can somehow control the birth rate and introduce planned parenthood with small families the spectacle of vast areas of slums existing side by side with palatial multistoried buildings would continue to mar at even a bigger scale the landscape of all big cities. They would also become focal points of social tensions. Experience tells us that a few island of richness in vast area of poverty, a few cases of affluences in a vast desert of penury and privation generate tensions and give rise to dangerous thoughts which portend ill for the smooth march forward of the society. Wisdom lies in forestalling such social convulsion and in taking timely steps to prevents occurrence. Family planning is one vital step for this purpose.

I think the organisers for asking me to address this August gathering on a vital issue. □

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Health as A Fundamental Human Right

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Health as a fundamental human right should be the cornerstone of any health policy anywhere. This has been recognized assertively in the Declaration made by the International Conference on Primary Health Care at Alma-Ata (USSR) in 1978,[1] to which India is a signatory. Expressing the need for urgent action by all governments "to protect and promote the health of *all* the people of the world", in the very first Declaration health is delineated as "a fundamental human right."[2] Here "health" means not merely the absence of disease or infirmity, but "a state of complete physical, mental and social wellbeing."[3] The emphasis on "all" is here to draw our attention to "the existing gross inequality in the health standard of the people" not only between developed and developing countries but also within the same country.[4] This means that, so far as health care provision for bringing about the required health standard in any population is concerned, no discrimination is justifiable on any ground whatsoever. It is "politically, socially and economically unacceptable."[5] An attempt to realize this very objective is reflected in our resolve to provide "Health for *all* by the year 2000 A.D." which includes provisions of at least a minimum package of health care services to all segments of the population.[6]

The signification of projecting health as a fundamental human right is that it becomes the basic responsibility of the State to protect and promote health of the population under its jurisdiction. According to Alma-Ata Declaration such an obligation "can be fulfilled only by the provision of adequate health and social measures,[7] which are "based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation."[8]

Indeed one of the major preoccupation of the present International Conference is how to discover and determine our own priorities and strategies for "optimising the social uses of medical knowledge and technology," consistently with our own "historical, cultural, moral, religious, philosophical perspectives and values systems."[9]

Concurrently with the developments at Alma-Ata International Conference, the Indian Medical Association, the national organization of the qualified practitioners of modern scientific system of medicine, started a crusade for the acceptance of health as a fundamental human right,[10] and a sound National Health Policy for fulfilling such an objective.[11] Eventually, we now do have a National Health Policy of 1982-83,[12] envisaging "an integrated, comprehensive approach towards the future development of medical education, research and health services" for meeting "the actual health needs and priorities of the country."[13]

Health as a fundamental human right envisages, as stipulated earlier, two things: one, the notion of health, understood in a comprehensive sense, involves irreducible minimums of prevention, promotion, curative and rehabilitation measures, and not just one leaving the others out; two, it is a right for *all* irrespective of all other considerations. Keeping in view its all pervasive nature and also the societal interest involved therein, it becomes the first and foremost obligation of the State to protect and promote health as a fundamental right. The question, therefore, now is how and in what manner this challenge is to be met.

If we just broadly review the work done through successive Five Year Plans during the past 38 years since independence, we do notice some measure of success in the realization of health as a fundamental human right. Thanks to the modern scientific system of medicine, the mortality rate has declined from 27.4 (1941-51) to an estimated 14 (1980). The life expectancy at birth has gone up from 32 years (1951) to over 52 (1980). The infant mortality rate has come down from 135 (1973) to 125 (1978). Plague, which was a common killer disease, is not heard of now. Smallpox has been eradicated. Malaria which, prior to 1950, used to take a heavy toll of about 8 lakh lives, with an incidence of about 7.5 crore cases a year, has been controlled to a large extent, the incidence having fallen to 24 lakhs and less than 200 deaths in 1980.[13a]

However, looking at the demographic and health picture of the country, we find much more still remains to be done on the health count.[14] The high rate of population growth, for instance, continues to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one-third of the total deaths occur among children below the age of 5 years; infant mortality is around 125 per thousand live births. The extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated. Many eradicable diseases like Tetanus, Polio, Goitre, Tuberculosis, Blindness, Leprosy, continue to have a fairly high incidence in the country. A substantial share of diarrhoeal diseases and other preventive and infectious diseases, especially amongst infants and children, are caused by lack of safe drinking water, poor environmental sanitation, poverty and ignorance.

For meeting these challenges within a stipulated period (for instance, the target of health for all by the year 2000 AD), our National Health Policy proposes to make "the universal provision for comprehensive primary health care services."[15] Considering the comprehensive character of the primary health care, a large variety of inputs flow into health. The avowed purpose of these inputs is "to secure the overall national socio-economic development process, specially in the more closely health related sectors."[16] Such sectors may include drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and conservation of environment.[16'] But, notwithstanding all these efforts to bring about the socio-economic transformation, "not much headway is likely to be achieved in improving the health status of the people, unless success is achieved in securing the small family norms, through voluntary efforts, and moving towards the goal of population stabilization." This is what has been clearly perceived under our National Health Policy.[17] Besides, it is also now realistically realized that the goal of population stabilization is achievable only by substantial augmentation and provision of primary health care facilities on a universal basis. That there exists a close and direct nexus between the two is indeed the recurring theme of the revised 20-Point Programme of our national Government.[18]

For the realization of comprehensive primary health care on universal basis, the basic impediment idenitfied in the National Health Policy is the adoption of the Western model as *the* basis of our health services. This model is said to be "inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in our country."[19] The underlying limitations of the western model in the Indian context, as pointed out in the National Health Policy document, are:[20]

1. It has provided benefits to the upper crusts of society, especially those living in the urban areas.

2. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population.

3. It has led to neglect of the preventive, promotive, public health and rehabilitation aspects of health care.

4. It has tended "to enhance dependency and weaken the community's capacity to cope with its problems."

5. The education and learning of medical and health personnel in persuance of this model "has resulted in the development of a cultural gap between the people and the personnel providing care."

6. It has prevented "individuals and families in establishing a self-reliant community."

All these limitations, in terms of accepted national health policy, imply that, somehow or the other we should have the indigenous systems of medicine (Ayurveda, Unani, Sidha, Yoga, Naturopathy, etc.) in place of or besides the modern system of medicine as the prime basis of our primary health care approach, at least for covering the hitherto uncovered vast segments of our rural population. The rationale and the manner for doing so is simply this:[21]

> This resource of indigenous systems has not so far been adequately utilised. The practitioners of these various Systems enjoy high local acceptance and respect and consequently exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genus. Simultaneously, planned efforts should be made to . . . integrate their services (the services of the practitioners of indigenous systems) in the overall health care delivery system, especially in regard to the preventive, promotive and public health objectives . . .

A couple of consequences of this suggested shift in our health care delivery system are now critically examined here.

The first and foremost is that until now in India the benefits of modern system of medicine as the basis of our health care services has extended to people who are living in the urbgn areas. But, does this necessarily imply that the modern scientific system of medicine is unsuitable for our village population ? In our submission, it is not the modern scientific system of medicine which is principally bad, though it is a different matter that hitherto its beneficial effect is visible only in the urban areas and not in the rural ones. The real reason is that in urban areas the basic conditions of sanitation, including the provision of potable water, are met and therefore, the beneficial effect becomes instantly evident. On the other hand, the beneficial effect of the same system is neutralised to a great extent by reason of the absence of the same supportive conditions.

Another assertion in the National Health Policy document is that modern system of medicine as the basis of our health care policy creates a "cultural gap" between the people and the personnel providing health care: weakens the community's capacity to cope with its problem, and robs "individuals and families in establishing a self-reliant community." All this seems to indicate that modern medicine is inconsistent with the indigenous system of medicine and thereby a "cultural gap" and all that is created. This is entirely a misconceived assumption.[22]

The modern scientific system of medicine is *NOT* opposed to indigenous system of medicine. It should indeed be our proud privilege to know that the modern system of medicine has evolved from nowhere but out of our own ancient Ayurvedic System, and it has attained its present premier position with the help of scientists from all over the world.[23] It is a different matter that, notwithstanding this advancement, we do continue to have a certain degree of inalienable emotional attachment to our indigenous system of medicine, especially Ayurvedic System, which though for certain historical reasons could not develop scientifically by maintaining its original purity and yet, at times, still meets at least some needs of the people, especially of those residing in remote village and who do not have access to the modern scientific system. In his editorial, "Need for a National Health Policy," Dr. Gouri Pada Dutta has pictured our predicament in memorable words:[24]

> "The indigenous system as it stands today, is not capable of competing with modern scientific medicine, but remains as the carcass of a giant, who had once a magnificent might but now has become only a monument of pre-historic past. The emotional involvement with past legacy is blurring the vision . . . ."

Let the pregmatism be our guide and take over our dogmas, so that we are able to recognize and say: 'Scientific development has given to our national system of medicine an international status for the benefit of whole mankind.

By implication another often repealed stance in our National Health Policy document is that modern scientific system of medicine seems to be suitable only for hospital based and cure-oriented approach. This is also simply *not* true. On this count we would like to say and say categorically[25] that modern medicine is the only scientific system "which provides comprehensive, promotive, preventive, creative and rehabilitative services, and, therefore, is most suited to provide total health care delivery at the National level."[26] This is not an assertion of the whims and the fancies of the practitioners of the modern system of medicine. It is concretely based upon the *fact* that it is "through modern scientific system alone that WHO has succeeded in eradicating small pox from the entire region and is (now) making efforts for eradication of Malaria and Leprosy. Longevity has increased; infant and maternal morbidity rates have substantially been lowered. Epidemics are few and far between."[27] As far as prophylaxis (i.e., promotive and preventive aspects of medicine for ensuring positive health) is concerned, modern medicine is the only means by which communicable diseases and population explosion can be effectively dealt with.[28] With prophylaxis, coupled with safe drinking water, "60% of the morbidity and mortality can be effectively taken care of."[29]

There is no gain saying the overwhelming advantages of the modern scientific system of medicine. But, mind you, it gives us a double-edged sword, which can make or mar, Its potent medicines, if used with a qualified and competent knowledge, are indeed a blessing. If used with half-baked knowledge, catastrophe is only the next door neighbour. Hence, two things clearly stand out. First, in our national health planning it should be assumed that our country needs modern scientific system of medicine for the delivery of health care; secondly, because of their inherent power to make or mar, allopathic medicines should be administered only only by persons who are fully qualified to practice the modern scientific system of medicine, and not by those with half-baked medicinal knowledge.[30]

The concept of integrated approach is indeed commendable. Speaking functionally, it does not contemplate the concept of "Health Team" comprising personnel of various grades of skill and competence, each performing the given task within a co-ordinated action programme.[31] But, if the experience of the working of the Multipurpose Health Workers Scheme in rural areas is of any index, the integrated approach has proved elusive. This approach has led to the growth of half-baked doctors enjoying the official status of RMPs (Registered Medical Practitioners), whose capacity and credentials to "cure" with absolute certainity is anybody's Guess.[32] It is in this context, that the Indian Medical Association has repeatedly resolved to recommend to the State for banning the use of potent medicines by the persons who are either not qualified in modern system of medicine or whose basic orientation is in a system other than the modern system of medicine.[33]

There is an explicit statement in the National Health Policy that there is a "high local acceptance and respect" for the practitioners of indigenous system of medicine.[34] It is also stated as a fact that the health care facilities based on modern system of medicine have hitherto been made available to the urban elites and not to the rural poors.[35] The conjoined consideration of these two statements, especially from the angle of realization of health as a fundamental human right, prompts us to project one basic question: From whose point of view are we to access the relevance of the indigenous systems of medicine ? If we look at them from the point of view of the knowledgeable persons who can appreciate and understand the difference between the services rendered by qualified men in modern medicines and the services given by the practitioners of indigenous systems of medicine. the limitation of the latter would be evident. On the other hand, if the same is seen from the angle of illiterate or semi-literate villagers, who have never known anything better than what is being provided to them by the promoters of indigenous systems of medicine, the experience might be exhilarating. The experience is similar to that of an old lady, who had collected jungle woods and waited on the road side for some helping hand. None cared to pay heed to her plea except a man who happened to be a philosopher. Overwhelmed by his kindness, she expressed her feelings of deepest gratitude which the philosopher thought was absolutely unnecessary. Mournfully he mused: 'Has man fallen so low that the society has ceased to expect even this much!'

In fact, on the contrary, there is a scientific evidence to show that there has been no significant cultural resistence to the acceptance of modern medicine as long as it is available and accessible.[36] This can also be supported in the light of the fact that the number of the patients at the C.G.H.S. and E.S.I, dispensaries of modern systems of medicine is many times more than at the similarly situated dispensaries of the indigenous system.[37]

Now, if the Government feels satisfied at the expressed satisfaction of the rural people, it is nothing but a clear manipulation of the ignorant masses. Is this the commitment of the State to realize health as a fundamental human right!

Finally, there is an argument in the health policy document that the western model-based health care delivery system is "inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in our country."[38] Our response to the argument is simply this: For the realization of health as a fundamental human right, the whole problem is to be viewed essentially from the 'accural of benefit'—point of view and not from the 'cost'—angle. We feel firmer in this plea of ours because the realization of health as a fundamental human right is the fulfilment of a basic necessity, and it is the minimum obligation on the part of the State to pursue this social objective which is enshrined in our Constitution.

Moreover, money put in for the promotion of health is an invaluable investment. It results in the generation of human resources. Isn't it strange that, following the lead of developed countries, we in the developing countries do not mind in shelling out millions of dollars for exploring nuclear energy, oil energy solar energy, wind energy; but start feeling at once restraint when it comes to the development of 'human energy'; Realising the importance of health as a resource generator, Dr. H. Mahler, the Director General of the World Health Organisation, has pointed out perceptively that "everybody seems to be overlooking the fact that without human energy, there would be no kind of progress either socially or economically."[39] Let us, therefore, structure our national health policy in a manner which enabled us to realise health as fundamental human right through the full exploitation of modern scientific system of medicine, which is comprehensive, preventive, promotive, curative and rehabilitative.

Footnotes

1. The Alma-Ata International Conference was jointly sponsored by the World Health Organization and the United Nations Children's Fund. This Conference was preceded by a number of national, regional and international meetings on primary health care, held throughout the world in 1977 and 1978. The Conference was attended by delegations from 134 governments and by representatives of 67 United Nations organizations, specialized agencies and non-governmental organizations in official relations with WHO and UNICEF. See *Report of the International Conference on Primary Health Care (Alma-Ata* 1978), published by the World Health Organization, Geneva, 1978. (hereafter cited as *Alma-Ata* Conference).

2. Declaration I. (Emphasis added).

3. *Ibid.*

4. Declaration II. (Alma-Ata Conference).

5. *Ibid.*

6. See the Report of the sub-group on the 'meaning of health for all in the background of India's Health Needs,' in the *Report of Working Group on Health for All by 2000 A.D.*, (Government of India. Ministry of Health and Family Welfare, New Delhi, 1981), para 30, at 50. (Hereafter referred to *Report on Health*).

7. Declaration V. (Alma-Ata Conference).

8. Declaration VI. (Alma-Ata Conference).

9. See the circular letter of the Secretary General of the International Conference on Health Policy—Ethics and Human Values.

10. See (1978) 71 Journal of Indian Medical Association, No. 3, at 66.

11. The Indian Medical Association gave a call to observe September 1, 1978, as the "National Health Policy Demands Day" to mobilise a massive public opinion in the country and to induce the Government to enuniciate its health policy to meet the total health care of the people. *Id.*, at 86-88.

12. A Statement on the "National Health Policy" was laid on the Table of both the Houses of Parliament on November 2. 1982. The policy was discussed at length in both the Houses and was approved by the Rajya Sabha on August 4, 1983, and the Lok Sabha on December 22, 1983. (Hereafter simply referred to *National Health Policy*).

13. *National Health Policy*, para 1.2.

13 a. For this estimate, see *Report on Health, supra* note 6. See also *National Health Policy*, para 3.

14. *Id.*, para 4.
15. *Id.*, para 5.
16. *Ibid.*
16 a. *Ibid.*
17. *Id.*, para 6.
18. *Id.*, para 5.1.
19. *Id.*, para 4.2.
20. *Ibid.*
21. *Id.*, para 11.

22. See also for this conclusion author's IMA Award Winning Paper of 1980, Pragya Kumar, "Short Term Courses in Medicine: A Necessity or Political Gimmick."

33. See the comments of the Indian Medical Association on the Draft for Discussion on 'National Health Policy' in IMA Document—NHP. 1 (April, 1979), at 13. (Hereafter cited as *IMA Document.*).

25. (1978) 71 Journal of *Indian Medical Association*, No. 3, at 84.
25. See also *supra* note 22.
26. *IMA Document*, *op. cit.*, at 1.
27. *Ibid.*
28. *Id.*, at 4.
29. *Ibid.*
30. See *infra* note 33.
31. See *National Health Policy*, paras 7 and 9.

32. A report reveals that in the State of Punjab alone there were over 23,000 RMPs in 1979. They are in reality unqualified *vaids* who were allowed in 1967 by the then Government to get themselves registered by simply filing an affidavit and thereby becoming entitled to prescribe allopathic medicines. See *The Tribune*, February 16, 1979.

33. See the Resolution adopted in the Open Session of the 60th All-India Medical Conference held at Hyderabad on January 28-30, 1985, urging the Government to pass a suitable legislation for banning the practice of modern system of medicine by persons qualified to do so and making it a cognizable offence. (1985) 83 Journal of *Indian Medical Association*, No. 3, at 92.

34. *National Health Policy*, para 11,

35. See *supra* note 20.

36. See D. Banerji, *Social and Cultural Functions of Health Services in India*, (Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi), cited in *Training Capabilities of Primary Health Centres in India* (Technical Report 1), (National Institute of Health and Family Welfare New Delhi), at 2.

37. IMA Document, *op. cit.*, at 10.
38. *National Health Policy*, para 4.2.

39. See the Text of Address of Dr. H. Mahler, delivered at WHO Regional Committee for South East Asia, Thirtieth Session, Bankok, Thailand, 2-8, August, 1977, in *Final Report and Minutes of the Meeting of the Thirtieth Session*, New Delhi, September, 1977, at 64.

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Human Values and Quality of Life

—A Personal Statement

Prem Kirpal

In 1969 while serving as a Senior Specialist at the East-West Centre at Honululu in the beautiful Island of Hawaii, and also unknown to myself at the time afflicted with malignant cancer inside my body to be operated shortly, I wandered at the blueness and vastness of the Pacific Ocean and the lovely beach of our tiny Earth. From this wander of the beauty of Nature and some surge of creation inside, I wrote the following poetic statement on the "Quality of Life":

I—QUALITY OF LIFE

Life's quality is comprised of: palatable food to digest well and enjoy; enough space and scope to contain and express the needs of body and soul in the full awareness and respect of other bodies and souls; robust health with abiding element of youthfulness; and, above all, the sheer love of life-the gift of friendship and love, the sense of wonder and endless curiosity, the perpetual thirst for giving and receiving, ceaseless strivings for new creations, and the capacity to accept any outcome in full understanding and with utmost serenity, cheerfulness and gratitude.

Life is as good as one can live it and it is as big as one can hope, imagine, aspire and dare!

Its quality depends a little on luck and chance, but much on what we value and search and how we go about it with courage, dedication and faith.

In this way one *can* never fail, because even failure becomes almost success when it is preceded by the right quest and effort.

To shoot at the stars and fail is better than a timid and faint-hearted venture which may satisfy or reward, but cannot thrill and exalt.

The spice of life and its meaning and scope determine its quality in the depth, breadth and extension of consciousness, from the earthly and the human to the spiritual, even the cosmic, dimension of man's perception, experience and vision. There is no limit to life's quest and quality, and often we become what we love. Being and becoming are great gifts of consciousness and these should be treasured and developed in all ways, dimensions and potentials of man's psyche and his cosmos. Remember always that in Life and its Beyond we are related and joined together to all Creations and the experience of this Great Harmony is the wonder and savour of Existence. Give full heed to the vastness of life's scope and its endless potentials and be grateful for the wonderful gift of life.

This Statement has been inscribed permanently on the inner wall of a Public School not far from the river Ganga and the massive machines of the Bharat Heavy Electric. Hopefully its young readers derive more practical meaning from it than what I have been able to practise. Since 1969 I have written and spoken a great deal on the Quality of Life and Human Values in the context of education and culture at home and abroad at several international meetings under the auspices of the United Nations, but the above Statement of life's quality abides in both the spirit and concrete attributes of life's quality, which is basically reflected in the health of mind, body and spirit and the inner life of the human psyche.

It is, of course, essential to achieve physical survival and a certain measure of material well-being before the quality of life is experienced and treasured in the world of the mind and the spirit. For physical existence we need food, health, housing, education, work, worship, sex and play. For man as a spiritual entity we must transcend along the path of security, freedom, identity, sense of belonging, joy, confidence, love and creativity. For both being and becoming we must now, in the emerging planetary order of Mankind, explore, identify and practise human values upon which will depend the attainment of the quality of life for all, and not only the privileged few.

From our past of many civilizations, diverse cultures, different religions and conflicting ideologies we are moving towards the unity of mankind. The formulation of a general statement on human values for our time could help the shaping of appropriate attitudes, common beliefs and suitable criteria and content of education for contemporary man. Such a statement can be based on the following important concerns and aspects of man, common to all civilizations and culture :

II—HUMAN VALUES

1. Man and his Own Self

In order to take charge of one's life in an uncertain and fast-changing world, the essentials of personality such as physical and mental health, right balance and poise of mind, and moral and spiritual qualities of character should be valued and cultivated. Education and Culture need to be directed to the enrichment of character and the pursuit of goodness, wisdom and transcendence. The development of the inner man by the fullest flowering of man's potentials and totality of being should be encouraged in an atmosphere of freedom and security. Man's care of his own self calls for measure for measure of austerity, self-discipline, pursuit of self-knowledge and cultivation of serenity as well as intensity. The luminuous and balanced self ceases to be vulnerable. The power of the inner self should be directed to love and service of fellow-beings.

2. Man and his Fellow-man

Man's relationship to Society should be governed by principles of humanistic morality acceptable to all and reflecting the quality and sensitivity of human relations, based upon compassionate love, mutual understanding and appreciation, and respect for justice and solidarity of mankind. The invocation to loving one's neighbour should extend to all inhabitants of the planet. Such a relationship between man and his fellow-man has to overcome the divisions and barriers of the past and the present attitudes of superiority and smugness arising from inequalities of wealth, power and knowledge. Man's common predicament and basic humanity should be planted firmly in his consciousness and conduct by the fullest and wisest use of the resources and potentialities of communications. The exploration and understanding of man's psyche should strengthen common humanity.

3. Man and his habitat

Contemporary man's habitat extends from his home and local environment to the entire planet, involving the care and nurture of nature and ecology from which he derives great benefits. The resources of the habitat must also be preserved for posterity for which he holds his habitat in trust. The sense of belonging and gratitude generate loyalty, prudence and austerity, and in the care and management of the habitat man learns to live in harmony with others. Narrower loyalities and nationalistic pride and egocentricity lead to conflict and war. These should give way to global loyalities.

4. Man and his work

To a large extent man lives in and for his work, and his mental health and happiness depend upon the choice of work, its scope for action, expression and initiative, its contribution to his creativity, decision-making, pursuit of excellence and sense of self-esteem and dedication. While work affords satisfaction, enjoyment and self-realization, it can also bring obsession for success and lust of power. We should avoid such temptation and work in a spirit of non-attachment and non-violence. Frustrations and alienations resulting from deprivations of work or its satisfactions warp the individual and distort society. Socio-economic systems and education should rectify these.

5. Man and Art

All men are endowed with artistic capabilities in varying forms and measure, and the flowering of these depends upon individual urge and social receptivity. The manifestations of beauty differ, but its essence and inspiration are the same. The pursuit of the beautiful strengthens man in his humanity and elevates his cultural life. In work, education and life we should recognise and enhance the importance of the arts and the artistic spirit. Respecting the diversity of art and culture, we can sense and share in the underlying unity of mankind. The quest of beauty and the joy of creation reveal life's meaning and enrich its quality. The artistic nature of man should be fed and nurtured all through the life span. People should have the opportunity of appreciating other people's arts and cultures.

6. Man and his Technology

Technological advance should be for human welfare and for the enrichment of man's humanity. Uncontrolled mechanisation for sheer power and de-humanisation needs to be checked. By controlling and regulating technological advance and application of science we can improve human welfare and quality of life. Appropriate technologies should be chosen for practical relevance and efficient productivity, and also for their capacity to humanise life and spread culture. Technology should not be allowed to undermine or pervert the primacy of the human spirit which is the source of man's creations and the abiding values to live by. Technology must always be subservient to the ends of good life and humanism. As a significant reflection of man's relentless curiosity, inventiveness, perfection of methods and systems and mastery over the external world, technology projects important human values.

7. Man and his Ideology

Man cannot live by bread alone. Beyond the materials of economy, politics, science and industry, his restless mind and probing spirit need some beliefs to give meaning to life and its goals and purpose. Historical experience and human choice determine ideologies which are incentives to action in the present and guides to the making of the future. Ideology caters to emotional and mystical elements of man's consciousness as well as the quest of truth, faith and humanism. Ideologies are reflected in the diversities of cultures and choice of life-styles and systems. They can cause tensions and conflicts and lead to war and destruction. Ideology should be valued for its ennobling influence, its strength and integrity, its dedication to peace and harmony and its commitment to man's humanity.

8. Man and Time : The Stream of past, present and future

In his relationship with time man shares some compulsions and dreams not only with the fellow-man of his own time in life, but also with those who have gone before in history and those who have yet to come. The consciousness in time and the experience of the life-cycles contemplate the mysteries of life and death and the concept of eternity. Respect for the past with hope for the future strengthens man's care of his cultural heritage and pride in common endeavours and aspirations. Man's sense of history is a most precious source and guide to humanistic values, the understanding of human nature, deep humility and compassion; in the depressions and elections of the flux of history man recognises his eternal self and experiences the brotherhood of mankind.

9. Man and his Cosmos

Man has always pondered about the mystery of existence, the universe that lies beyond, and the larger scheme of life of which he is only a part. Imagination, intuition, mysticiam, and religion have all contributed to the quest of the Cosmos, the ultimate or the larger universe which may be glimpsed through worship, meditation, knowledge and poetry. Contemporary man has greater knowledge of the extent and nature of the universe than the past generations, and this knowledge brings us close to the life and unity of our own planet. We can all share in our common predicament of the planetary habitat, so small and insignificant in the vastness of space and time. The Cosmic dimension of life brings us closer to each other and gives a proper perspective to temporal existence. ☐

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Rural Child and Health Development Team

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The story of Child Health in India is one of needless, avoidable disabilities, and missed opportunities. Child Health is not an individual problem. It is a family and community problem and has to be tackled at the community basis. 70% of India's children live in rural areas. The health needs of the children in our country are entirely different from those of affluent countries and do not require sophisticated technology. There is a need to ensure that resources whatever their origin are channeled in to socially relevant health action-Multisectorial Mass Action for social change. A comprehensive National Health Policy has been accepted by the Parliament signifying the political and Government will to Achieve Health For All by 2000 A.D. The targets to be achieved stresses the importance of Maternal and Child Health Services. The policy emphasises the preventive, promotive and Public Health and rehabilitation aspects of health care and establishment of Primary Health Services, to reach the population in the remotest areas of the country. Ensuring adequate Nutrition, safe drinking water supply and improved sanitation for all segments of the population and Health Education are the other highlights of the Policy Document.

Like any other field of science, Medicine is witnessing a knowledge explosion in all aspects. Advances in Paediatrics started as a trickle in fifties, became a rivulet in sixties, a torrent in the seventies and a flood in the current decade. There is a wide gap between available knowledge and its availability to the most needy. Obviously we need a break through not only in science and technology but also in organization, management, education and motivation. It is in the application of what we know that we are failing even more than in the discovery of new knowledge. It is a tremendous challenge for all of us if we wish to meet the Rural Children's Cause and Commitment.

The nation has developed a plan for rural services to meet the needs of Mother and Child Health Care and Family Welfare. The assessment of available resources, their proper allocation, efficient utilization are important considerations for providing efficient Health Care Delivery. Primary Health Care envisages a community based health system which will emphasise the interdependence of health and development in all ramifications and ensure the equitable distribution of available health resources leading to accessibility and efficient health care. So optimum mix of personnel of health and non-health sectors has to be done for most efficient health care services.

In India since our Independence, with the establishment of Primary Health Centres and Rural Community Development Programme, it was possible to take modern health development of people living in farflung and hitherto inaccessible areas. Still the improvement in Health and Nutrition Status of children is not commensurate with the effort. This has brought in to question, review of the entire activity of Health Care Delivery with a view to evolve a strategy more suited to the country's condition. Health is not medicine alone. Health development cannot be restricted to the development of medical technology alone or devising, ways of applying the technology. Primary Health Care has to look beyond health sector. It is time to veer away from the concept of Medical Personnel working in isolation.

The members to constitute the rural health development team and their job responsibilities have to be redefined. There should be a vigorous effort to integrate all agencies like rural development, agriculture, Womens' Welfare Education, Nonformal Education and voluntary associations and departments involved in the challenging task of improving the quality of children everywhere. There is a need for a fundamental change in the organisational set up in the block level. In the present changing situation the Health Development Team has to co-ordinate various activities to maximise efforts and accelerate development.

Team is defined as a group of people working together towards a common goal. Team work is pooling of efforts co-operative working for a common cause. All group of workers concerned with health development, promotion, maintenance and recovery of health and prevention of diseases- are members of 'Health Development Team'. These members have different qualifications, grades, strength, experience with different types of responsibilities varying according to the tasks it has to perform. The challenge of achieving uniform health development is greatest in the villages. All sectoral plans and programmes for the social development in the villages have isolated approaches quite independent of each other with obvious overlap. It is imperative that if we are serious to achieve meaningful results within the next decade, within the financial resources, there is no alternative to the exploitation of available manpower and financial resources, available with various departments and agencies concerned with Growth and Development, in the most well planned and co-ordinated manner. All vertical programmes running virtually independent of each other with very little co-operation at planning, supervisory and field levels have to be integrated totally and formulate well planned and co-ordinated practical programmes. Ivan Illick says 'there is a great deal of medical capability outside the medical profession and unlimited opportunities outside formal institutions'. So the functionaries at the block level who should be the members of the Health Development Team are to be from all walks of life.

From (1) Health and Family Welfare
(2) Rural Development
(3) Social Welfare
(4) Education
(5) Non formal Education
(6) Water Supply and Sanitation
(7) Agriculture
(8) All Voluntary and Philanthropic Institutions
(9) Mass Media.

The objectives of the team will be, all the welfare activities including health is to be expanded to cover all the population, particularly the vulnerable, improving the functioning and utilisation within the present system.

All the concerned team members should be made to

(1) understand the local maternal and child health problems well to develop a cost effective health care system.

(2) Study the problems in implementing existing programmes e.g. administrative obstacles, female illiteracy and the gap in out reach services.

(3) Study the conflicts in implementing welfare programmes for mother and children. (e.g.) deep rooted cultural beliefs.

(4) Learn how to provide technical education to family members and local volunteers.

(5) Learn methods of mobilization of people in the village particularly women for promotion of health.

(6) Understand importance of documentation of health events, evaluation and accountability.

Rules and roles for the team members can be so defined as to provide built-in flexibility, within a clearly defined broad policy framework. Each block can assign responsibilities and tasks, allocate resources, and set targets according to the local priorities, health and family welfare needs of the people. (e.g.) (a) areas where nutrition status is poor nutrition input must be maximum. In most backward areas female literacy must have top priority. Many of the maladies of the present system can be cured at the village level by a very effective team by involving the family itself. The goals to be achieved also has to be streamlined. (e.g.) The short term goals of the team will be, achieving.

(a) 100% Antenatal care
100% Natal care
100% immunization coverage
100% Infant follow up.

(b) Training and educating the team in recent advances in child health care. e.g.) growth monitoring, oral rehydration therapy, breast feeding, weaning and food supplementation, female literacy and family spacing.

The overall objectives of education and information with communication programmes of the team is, to educate and mobilise the neediest sections of the rural population so that, they can themselves initiate actions to achieve and maintain an acceptable standard of health and family welfare.

The long term objectives will be-

(1) To inculcate a sense of self reliance and discipline in all segments of population, so that all four sides of the health square i.e. prevention, promotion, cure and rehabilitation are effectively handled at the local levels consistent with development in the field of medicine.

(2) To improve public health and public health services, to achieve health for all with expected reduction in mortality and morbidity.

(3) Universal education and total female literacy.

Training and education of the team and through them the community is a challenging task. It is on the ability to elevate the standards and reliance of the community the success can be judged.

Success in one area will turn up problems from an unexpected direction e.g. once malnutrition and infection is tackled, cardiovascular degenerative diseases may take an upperhand. The team also should anticipate and plan programmes for the future.

This approach will help all to move from knowledge to action.
Tomorrow is too late to help to-day's children. ☐

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Man, Medicine and Law: Challenges of the 21st Century

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1. Introduction

Bio-medical and technological advances have forced not only a redefinition of some concepts in other disciplines, but also necessitated a widening of the perspectives of medical science. Science is no longer the concern of scientists only. It is no longer enough for the man of medicine to confine himself to the traditional learning of his own discipline. Whether he likes it or not, he has per force to expand the horizons of his mind and to take note of the points of view of other disciplines and to meet the demands of norms flowing from the principles evolved by other disciplines. Dramatic and frightening progress in knowledge, particularly in genetics and biology, and radical advances in techniques, especially in re-constructive surgery and in surgery connected with the process of reproduction, have raised issues of great consequence to humanity. Some of these issues are already of pressing interest, such as abortion. A few others, if not of pressing interest today, are bound to cry for answers tomorrow. It is only if we start thinking about them today, that the answers will be ready tomorrow.

It has been said that science often seems to thrust society into directions which society only partly understands and certainly has not chosen. This makes the task of social scientists and thinkers on ethical problems fairly difficut. They must first understand the directions of science and then offer guidance as to the implications of scientific advances, and elucidate to the best of their ability the choices open and the merits and demerits of each such choice. Knowledge must thus come first, but it has to be followed by wisdom, which a great jurist once described as the "elder sister of knowledge".

Both science and ethics have a common origin, as part of the process of civilisation which distinguished man from apes. In its earliest form, science was an attempt by man to understand the phenomena of nature and to exploit the resources of nature for satisfying his instinctive need for food, shelter and protection. The beginnings of science freed the man from the drudgery of hunting. Settling down in groups and cultivating his own food gave man the security and leisure needed for pursuing a life—style different from that of the ancestors of mankind. This inevitably led to the subtler things of life—language, writing, the arts, music, poetry, religion, ethics and law. In ancient civilisations, scientific thoughts flourished hand in hand with religion and ethics. Scientific discoveries were considered revelations. The great writer on the Indian science of medicine Charaka was an ascetic. Aryabhata (5th century A-D.) who propounded the revolutionary theory of rotation of the earth stated that his knowledge owed itself to the grace of God. Al Biruni, the famous Arab mathematician, insisted that his experimental work was subject to the moral principles of Islam. When, in 1543, Vesulius, a physician from Belgium, published a book on human anatomy based on dissection and personal observation, he expressed his wonder at the "handiwork of the Almighty, by which the blood sweats from the right in the left ventricle through passages that escape human vision". The feeling of antipathy between science and religion was a later development, of which Copernicus and Galileo were the victims.

2. Nature of the issues

This paper does not seek to present an exhaustive treatment of the impact, on humanism, of medical advances or a comprehensive catalogue of the ethical and legal issues arising from such advances. But it seeks to point out some peculiar features of those issues that are very relevant to an understanding of their social significance, so as to facilitate the formulation of a correct approach.

Usually, such issues are seen as presenting a conflict between medical science and non-medical disciplines. However, this would be taking only a partial view of the matter. In a sense, science is neutral, because it does not take sides. The business of science is to discover the fund of knowledge, to organise it and to present it. What use to make of the knowledge, and whether to make use of it at all, is a question on which the scientist, speaking as a scientist, does not claim superiority and would not claim the privilege of his speciality. It is in this sense that science is neutral. When one speaks of a conflict between medicine and other disciplines, one should not imply that there is an antagonism or antipathy, as such, between what medicine demands and what society desires or ought to desire. The truth is, that the conflict really in here is in the conflict of interests, conflict of demands, conflict of desires and conflict of approaches between two individual members of society, or between society and its one or more individual members. For example, if one comes to questions of life and death and is concerned with the precise issue as to the determination of the exact moment of death, one finds, on a deep analysis, that two rival approaches are competing for recognition. It may be described as a conflict of values. The traditional concept of sanctity of life and of the peremptory moral obligation of society to maintain that sanctity at any cost, is one of the competing values. Pitted against this is the emerging movement for "dignity in death" and "the right to die". The latter movement has been regarded as an extension of individualism. It is an extension of the individualistic principles of self-determination, autonomy, integrity and self-realisation and the choice to exercise control over one's dying as well as over one's living.

3. The debate about abortion

The conflict of interest between two individual members of society is illustrated in the debate about abortion. The conflict here is between the mother and the yet unborn child. Of course, it is a conflict of a complex character, in which so many moral and scientific concepts or doctrines are entangled, though very few persons are able to perceive that the fabric is inter-woven with threads of an infinite variety and number which criss-cross each other. Simply stated, the moral question is this: Whose desire or interest should prevail? Should the mother's desire prevail or should the interest of the unborn human being be given precedence? In a more complex form, the questions are really multiple. Should society recognise any right at all in the unborn? To put it in legal phraseology, should the zygote, the embryo or the foetus be regarded as a "human person" and, if so, from what point of time? When does the right of the embryo to protection begin? At implantation? At the end of the first trimester? At quickening? At viability? At the moment of birth? Assuming that the right of the foetus begins at one or other of the moments just now referred to, under what circumstances can the right of the unborn be overridden by the desire of the living and, at what point during gestation? If both the foetus and the pregnant woman have rights, the one to its survival and other to terminate her pregnancy, who is competent to adjudicate the conflicting claims, and what are the qualifications for such a role?

4. The right to live

The situation of abortion, mentioned above, involves a consideration of the two-fold obligation of the State towards the unborn life. (1) The obligation to refrain from all interference with unborn life, and (2) the obligation to prohibit an attack upon unborn life stemming from a private person. Obviously, any law which permits abortion upto a certain stage of pregnancy places unborn life at the disposal of society, though this decision is taken in the name of higher and more paramount demands. The conflict is seen in a more dramatic form when one comes to the right to life and the right to die. The right to live is at issue in the unending debate about the ethical aspects of prolongation of life by artificial means. In a deeply unconscious individual whose vital functions are maintained over a prolonged period only by extraordinary means, the question arises whether a time comes when it is no longer appropriate to continue the extra-ordinary means of support for the hopelessly unconscious patient. If man is regarded as being in the image of God (*imago dei*) then, theoretically, the duty to prolong life has no closing terminus. So long as the vital functions persist spontaneously or with the aid of artificial process, "life" survives and must be prolonged to preserve the 'image". This is one aspect of the matter. Apart from this religious aspect, there often comes to be presented a conflict of interests, though the conflict is not articulated. The family of the patient very often wants to terminate the agonising watch and may urge a discontinuance of extra-ordinary measures for prolonging life. Those who have an interest in organ transplantation might press for a new appraisal of what constitutes "death". The hospital authorities and society in general have a vested interest in terminating a costly procedure in a hopeless case. But the presence of these vested interests raises the possibility of selfish "rationalisation" of the course which the vested interests wish to adopt. It gives a warning of the need for a cautious approach. One may also remember that the termination of extra-ordinary care, even for just reasons, with death certain to ensue, can have a shocking effect on observers.

Some of the problems discussed here arise even out of the existing canons of medical ethics. The current code of ethics of the Indian Medical Council, in paragraph 3, provides[1]—

"I will maintain the utmost respect for human life from the time of conception."

In paragraph 7 it provides—
". . . I will respect the secrets that are confided in me."

5. Artificial insemination

Some of the techniques evolved by medical science give rise to legal as well as emotional problems. For example, there are emotional problems born of artificial insemination, which is now frequently used to help infertile fathers. Some fathers later resent children born as a result of A.I.D. Mothers have also been known to develop a romantic infatuation for the unknown biological father. The practice is to keep the donor's name secret from the parents. But legal problems may arise if the parents demand, say, a tall or vegetarian donor. There is also the question of legitimacy of the child born of A.I.D.

6. Genetic techniques, and IVF

Placed in the social context, any one genetic technique can be assessed from a number of different angles. The several frames of reference which apply, say, to a decision on abortion, include exploring it from the point of view of (i) the parents, who may or may not have a deformed child, or (ii) society, which may or may not wish to spend money on the care of children, or (iii) the child yet unborn, whose right to protection may require to be considered.

In vitro fertilisation is not simply a device to be marvelled at, as an instance of science fiction turning into science reality. It raises in our mind serious questions of ethical and social policy; for, genetic technology has the potential to take human heredity out of the realm of blind faith or chance into the realm of free will and choice. In the past, nature took the blame or the credit for genetic inheritance. This responsibility is increasingly becoming ours, because of expansion of the area of choice.

7. Coercive genetic and surrogate motherhood

This does not mean that "coercive genetics" (the prescribing of legal sanctions against the use of genetic techniques) should be readily resorted to, either to force the weeding out of undesirable genes or to prohibit the use of new techniques. Excessive intervention by the State would completely undermine the legitimacy and moral basis of Government. It is in this context that the most difficult issue is presented by surrogate motherhood. However morally shocking the practice may be, a legal prohibition may well remain unenforceable. What matters in such cases is the social feeling. As has been often pointed out, most new genetic techniques, once developed, would bring much joy to parents and cause little discernible harm to society. The State may, therefore, be well advised to guard itself against the urge to legislate in this field. Improvements in genetic technology may well excite the appetite of the State to interfere by legislation, but the tendency will have to be curbed.

8. Inchoate rights: the question of privay

The situations so far discussed concern themselves with legal or moral rights whose existence is undisputed. Besides these, however, sometimes there are involved rights which themselves suffer from obscurity, because of the prevailing uncertainty about their existence and recognition. Here the shadow on a correct appreciation of the ethical issues is not cast by any scientific advances as such, but arises from the hazy nature of the very rights themselves, whose existence and precise dimensions have not yet been demarcated in traditional legal and ethical thinking. Privacy is an example of such a right.

9. Privacy and informed consent

Of late, the doctrine of informed consent to medical treatment has come into prominence. This doctrine initially came to be premised on the patient's right of self-determination. This is instanced by the famous words of Judge Cardozo [*Schloendorff* v. *Society of New York Hospital* (1914) 105 N. E. 26]. The patient's right to information before consenting to treatment may also receive support from the principle of the right to privacy—being the principle of an "inviolate personality" which posits the individual's independence, dignity and integrity. It may be mentioned that of the several facets of this right as explained by Mr. Justice Douglas [*Roe* v. *Wade*, (1973) 93 Supreme Court 705], the third deals with the freedom to care for one's person and health.

10. Bio-ethics

All this naturally brings one to the new discipline of bio-ethics. Broadly, is a discipline dealing with the ethical implications of biological phenomena as manipulated or encountered by the science of medicine. It dwells on the frontiers of medicine and ethics, Because it dwells on the frontiers, it has its own excitement. Sir Ernest Gowers once said that the crossing of intellectual frontiers is always a thrilling experience, just as it is a thrilling experience to cross the physical frontiers of one's own country.

Bio-ethics is not a totally new subject. In some form or other, the medical profession has always had something to do with ethical issues. The celebrated works of Charaka (probably 100 A.D.) on the Indian system of medicine contain an elaborate code of ethics for physicians. Amongst the mandates that Code contains, is a direction to the physician to strive for the relief of the patient with heart and soul. It also directs the physician not to treat a female patient, unless a male relative is present.

Four goals may be concretely indicated in regard to the discipline of bio-ethics: (1) identifying the moral issues in a bio-medical context; (2) developing appropriate strategies for analysing moral problems; (3) relating moral principles to specific issues; and (4) training a small group in bio-ethics.

The first two goals imply that the physician is not a primary decision-maker, but rather one who assists the patient in coming to his own decision where a moral issue is involved. The physician must learn how to distinguish technical questions of medicine (which are appropriately his own area of competence) from value dimensions (which are not exclusively his own area of competence).

A regards the third goal of bio-ethics (relating moral principles to specific cases), this will be for the patient, he being primarily the decision-maker. But some ethical issues can still remain for the physician—e.g. how much information is to be transmitted to the patient about a particular diagnosis.

11. Conclusion

To conclude, let me quote from Dr. A.S. Duncan's foreward to Alastair Campbeil's *Moral Dilemmas in Medicine*: "Curricula have become so loaded with the very scientific and technical matters which lead to the dilemmas that little time is left for thought as to the dilemmas, themselves. As Harold Laski wrote, "expertise sacrifies the insight of common sense to intensity of experience." Where human problems are concerned, the expert fails to see that every judgment, which he makes, not factual in nature, brings with it a scheme of values which has no special validity about it. □

Reference

1. See George Lobo Current Problems on Medical Ethics (Paul Publishers, Allahabad 1974) Pages 215-228.

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Demands of Few vs Needs of Many

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"The right to health is a fundamental right"
W.H.O.
"A state of complete physical and mental and social well-being"
W.H.O.
"Complete freedom from disease and from struggle is almost incompatible with the process of living"
Rene Dubos

Health is different from pleasure and happiness. As opposed to health, in happiness there is hierachy. A happy man wants to be happier; getting one measure of happiness, he desires to get a greater measure of happiness; getting one kind of happiness, he longs for other kinds of happiness.

The highest value held out in Indian thought is not happiness or 'sukha' because happiness necessarily presupposes its invariable concomittant, unhappiness : the two constitute a pair. One cannot be there without the other. On the other hand, peace of mind (shanti) is freedon from all opposites and is therefore, the highest objective. Peace of mind (shanti) is defined as that, obtaining which, one does not seek to obtain anything else. It results, when there is no longing and thus no stress. There are no levels or kinds in peace of mind. A person who is content, does not aspire for more of it; if he does, he ceases to be content'. Thus it eliminates rivalry, strife and stress. It is an attitude of mind that is cultivated, in order to preserve and promote health and to prevent ill-health. Peace of mind is within easy reach and can be attained by a large majority of people, irrespective of caste, vocation, knowledge of philosophical truths and so on.

Health is possible only for mortal beings, for we are born with the twin inherited and inescapable 'diseases—ageing and mortality'. To lack health is a misfortune than misdeed. Health is more beauty than virtue, more an aesthetic than ethical term. One does not condemn some one for 'no longer being healthy'. Then, are our goals for attaining health or prolongation of life ? If we aim at the latter, we go after the diseases that are the leading causes of death, rather than the leading causes of ill-health. When we tend to evaluate in terms of mortality statistics, we invariably mean changing one set of fatal illnesses or conditions for another. Prevention and treatment of causes of ill-health may enable the prospective or actual victims to live longer.

Modern system of medicine, which is most widely respected of professions and which has never been more competent technically is in trouble.

Its health is not too well. The reasons are medical care is very costly and not equitably available. The average doctor sees may more patients than he should, yet many fewer than would like to be seen. In fact a modern doctor is overtrained for the job he is doing, yet undertrained for the job he is expected to do. On the other hand physicians powers and expectations from him have grown enormously, owing to explosion of knowledge and modes of diagnosis and treatment. His responsibility have grown as well. All kinds of problems now roll to the doctor's door from sagging anatomies to suicide, unwanted childlessness to unwanted pregnancy, marital maladjustment to learning difficulties, genetic councelling to drug addiction, from laziness to crimes. It is iromic but not accidental, that the great technical power of medicine is under confusion about its standards and goals for guiding its use. When its power was fewer its purpose was clearer. In fact, medicine was considered the very model of an art in the past. Today, although fully armed and eager to serve, its targets are no longer clear. Now health is not the only possible and reasonable goal of medicine. There are other goals as well Eg. removal of womens breast because it interferes with her golf swing, performing vasectomy, tubectomy as family planning for non-medical reasons, artificial insemenisation etc. Hence happiness is a false goal of medicine.

Without a clearly defined end views, medicine may prove to be only a set of means, and doctor being reduced to a technician and engineer, of selling his services on demads. This meands transforming the physicians into a helper for hire. 'Endless' profession is an 'ended profession'. A doctor should not be tyrant but neither must he be a servant. Doctor should remain as a leader and teacher. Public misperception of medicine is ultimately more dangerous than the doctors misperception of himself. The community must respect the fact that medicine is an 'art' and doctor is a 'docere'.

We need to advise better indices of healthiness than mortality and morbidity statistics. Thus the importance of epidemiological research in healthiness—about what promotes and what undermines health. Sophisticated studies in nutrition, exercise, rest, sleep, relaxation, response to stress are integral subjects of research. We need to identify and learn about health sub-groups in the community and to discover what accounts for their success Eg. change in eating habits, and new treatment for hypertension has shown a downtrend in death rate from heart attack in middle age groups. This approach would appear pedestrian in comparision with the dramatic style of high technology and therapeutics. One has the highest respect for noble prize winners, for the discovery of chemical wonder of enzyme structure, but surely he who suggested adding chlorine to drinking water or invented indoor plumbing system and closed drainage have contributed more to healthiness of human kind. What is actually important to note is that major improvements in mortality in Europe and USA occurred before the massive investment of the last few decades and before the advance of 'high technology' in medicine.

Mortality rates among children, young adults have continued to improve but not at an enhanced rate and gain in expectation of life at the age of 65 have been far from dramatic. It spite of enormous scientific development and availability of drugs and high technology machinery, the improvement in mortality has been disappointing. Complete eradication of heart disease, cancer and stroke—currently the major mortal disease, would according to some calculations, extend the average life expectancy at birth only by approximately six or seven years, and at age 65 by more than one and a half to two years. Medicine's contribution to longer life has nearly reached its natural limits.

There are several countries, where spending on health services is not below 10 per cent of the gross national product (West Germany, Netherlands, Sweden, USA). People are now working for a five weeks year, simply to pay for their health services—less premature death, less illness and disability, less pain more comfort and support and care when disability cannot be further ameliorated. There is serious doubt, whether richer countries of the world have in fact gained any commensurate benefits. There is a point at which people want to keep their own money to spend in their own way. Bulk of the money in health care goes to a small minority who are seriously ill. There may well be a limit on what the healthy are prepared to spend on the unhealthy.

CT scanner is the greatest development in radiology and has enormous diagnostic potential but between 1973 and 1977, UK installed 30 brain and 11 body scanners. In USA in the same period, over 760 scanners including 200 body scanners were installed—if each of these machines did 2000 scanners a year, at average charge of US £300, the annual cost would be $456 millions. Being excessively impressed with the technological brilliance of big hospital medicine, mobilizing crusades and crash programmes against cancer and heart disease, the health politicians speak as if more money, more targeted research, better distribution of services, more doctors and hospitals, and bigger and better cobalt machines, lasers, and artificial organs should bring the medical millennium to every citizen.

Planning must not be vague, unless justified on economic grounds, increased efficiency or training, new and sophisticated equipments, and big hospitals can become 'white elephants', One approach to the problem of cost containment is to restrict the supply, both of hospital beds and of medical man power.

One view is that further preventive efforts may be more cost-effective than further investment in curative media. Equally important is the fact, that a section of intelligentia both in and out of medicine, have begun to wonder aloud, whether and to what extent medicines are doing good.

The countries that appear to spend the most on health services do not necessarily have the best health. Spread of free or nearly free health services to vast majority of the population does not seem to have narrowed relative social class difference in mortality risks. The 13 year increase in life expectancy from 1950 to 1970 for persons over 25 years old, who are non-smokers, is also most halved for those smoking more than 25 cigarettes a day. We are irrationally suspicious of any attempt to modify our personal behaviour, even if it kills us.

> "*A man who has built a fire to warm himself, but continues to fire it, until it begins to roast him*"
>
> *Plato*

Frankly he seeks ingenious devices to measure his discomfort accurately and to cool himself down, dazzled by the roaring success of his life, he fails to see, that the obvious remedy is to put less wood on it. Modern medicine is often pictured as a stunning breakthough. Technological revolution have evidently fostered this image. 'Technology' reign as the primary shaper of medical progress has been strongly challenged. not only in terms of the financial drain but also in terms of its outcome on the nation's health—its excessive use and the possible risks to patients and societies. Technological revolution has become a controversial issue. Now it is 'Technological Problem'. Therefore developed countries have a lesson to teach the developing countries from their experience—may be negative rather than positive 'Don't do it our way'.

The trend towards high technology evidently leads to a disequilibrium in type and distribution of services provided, with too much emphasis on acute institutional care and too little on more essential care, for huge segments of the population. In countries with more limited resources, it obstructs the development of priority health services, thus possibly contributing to a deterioration in the population health. The developing countries should not be mislead by developed countries. Gross attempts to transfer successful structures from one country to another, can lead to reactions out of proportions to the often minor adaptations needed to fit them to the recepient country's values.

Poverty is the key vector in the developing countries. Poverty creates illness and illness creates poverty. Health planning is a question of economic and social planning rather than medical planning. Industrial development would help a small urban elite. There is relatively high expenditare on health services in urban areas, concentration of resources, hospitals and trends towards physicians based security schemes. Usually training included doctors and specialists, medical education of the curriculum of more developed countries, heavy expenditure on imported gadgets and pharmaceuticals, service heirarchially controlled and at the same time vast majority are denied science based service and spend heavily on herbal remedies and traditional practitioners.

It is interesting the relatively low priority is given to health compared to other areas such as ornaments, hotels or air lines in developing countries. Health does not seem to be a priority.

Inadequate investment on the physical and mental well being of the people can only mean a proportionate decline in the economic development of the country. Putting greater pressure on its resources.

Pharmaceutical progress eliminated suffering and sadness, has benefitted modern medicine by the saving within the health service itself, saving from the reduction of loss of working days and savings from the elimination of premature death. For the vast majority of the rural population, it is now accepted, that basic and generally well established medicines are what is needed Eg. vaccines and antibiotics.

A case in point is that there are nine million blind persons in India—3 out of 200 persons and 3 million of them are preventable. 25 lakhs of children are estimated to go blind every year and 1.25 will need to be protected annually with vitamin A—50,000 units costing Rs. 2 per child with a total cost of Rs. 25 lakhs as against Rs. 25 crores for feeding, educating and care of the blindand loss in terms of human happiness. Forty per cent of population are found to suffer some degree of iron deficiency anaemia which could be rectified by oral iron therapy, costing hardly Rs. 2 to 5 per person. Appropriate technology for health and rationing of services could lead to rational solutions. The need to eliminate waste and improve cost-effectiveness, and the principle of equal distribution of service in population.

In many areas of social life, policy and action still continued to be improved on the basis of prevailing beliefs rather than on informed appraisal of issues and alternatives. In meeting health needs, technology must be geared both to the problems to be solved and to local conditions. It should be scientifically sound, acceptable to those who apply it and to those for whom it is used and affordable to the nation.

Each country and each society has to decide its own health priorities. Good information is crucial to good decision making. Their use must justify the effect involved.

The stock of skill or human capital must be allocated in such a way as to reduce the cost of any particular treatment.

India has an abundance of men of intellect and aptitude for medical research, but they should be given all facilities and encouragement. The declaration of Alma Ata, proclaiming health for all by 2000 AD enjoins upon research, to gear its efforts to fulfil this goal. The challenges have to be met by appointing TASK Forces, comprising groups of experts in respective medical fields, who should formulate specific targets and time bound projects in the given fields and identify the priority areas with regard to their national relevance. IMA will also be happy to associate itself with this task and help the various medical research institutions with a proper feedback.

सर्वे जना: सुखिनो भवन्तु

"*May the whole world be healthy and contented*".

References

Concept of Health and Disease—Interdisciplinary Perspectives

—Edited by Arthur L. Caplan; H. Tristram Englhardt, Jr.; James J. Mc Cartney Addison—Wesley Publishing Company—1981.

Economics and Health Policy—Edited by A Griffiths and Z. Bankowski

—W.H.O. Publication—1980.

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Identifying Indicators of Quality of Family Life

As Assessed by Satisfying and Satisfactory Conditions in Mentally Retarded Children

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"The Constitution of the World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

"The identification and monitoring of indicators of mental health in all its facets, including subjective well-being and quality of family life, is a matter of priority in the regional mental health programme of the SEARO, WHO. [SEARO (1984): Indicators of Mental Health. Report on a WHO/UNICEF Inter-country Workshop. SE/Ment/79].

"Mental health refers to the full and harmonious functioning of the whole personality, that gives satisfaction to self and benefit to the society."

"One of the related concepts used increasingly in the scientific as well as in the lay press in recent years has been the concept of *Quality of life*. Being somewhat polymorphous, it tends to cover a variety of areas such as physical and psychological complaints, feeling of well being, personal funtioning and general limitations."

"It is important to add quantity to years, but it is *more* important to add quality to years."

"Mental health can give quality of life."

"Quality of life need not be poor in a poor man's home, nor in a handicapped person's home."

"Quality, beauty and virtue lie in the eyes of the beholder."
"We should try to plan with the people and not for them."

Introduction

In order to add quality to years, it is necessary first to define, describe and assess the quality of family life. Adding quality to life is perhaps as important as adding years to life, if not more important Quality of family life may be defined as the degree of excellence (a) with which the family is integrated as a unit, acts and together faces life problems and (b) with which it contributes to the satisfaction and happiness of the individual members, with benefit to all concerned i.e. those within and outside the family unit. It refers to the extent to which it accepts the individual contributions of family members and the extent to which it contributes to their physical, mental , social and spiritual well being. No doubt, it is a difficult area to define, as many of the factors may be ill defined inter-related and to some extent interdependent also. The above operational definition may suffice till the time a better one is offered and found to be universally applicable and accepted.

Quality of family life, an expected, would be affected by a number of significant positive and negative life events.. The actual birth of a mentally retarted child in the family, its knowledge and related consequences real or imagined, on the life of family members and atmosphere of the family as a whole, etc. may be one group of factors that could possibly, adversely affect the quality of family life. The way of family faces such a situation and copes with related problems is likely to reflect the quality of family life.

There is no dearth of studies on the possible adverse effects of the knowledge of the presence of mentally retarded child in the family. They do indicate varied reactions in the families and among its individual members. The reaction ranges from initial shock and denial to partial or more or less total acceptance—the last being rather a rare phenomenon. Sometimes it may also lead to rejection of the child—physically and/or psychologically. This determines as well as determined by the existing quality of family life.

It is important, therefore, to find out as to what are the possible indicators of quality of life in such families. This is particularly so, in view of the increasing studies on the role of parental training to handle and train such children at home. The indicators so identified, could help in the evaluation, monitoring, and comparisons of relative effectiveness of such programmes.

After defining the broader construct of Quality of Family Life, it may be useful to devide the whole area into a number of measureable specific constructs which can then be defined and items constructed to measure them adequately and reliably. Emphasis should be more on practical, measureable and tangible aspects and relatively less on abstract theoretical constructs that may be difficult to be defined and assessed by the majority of our population that usually have low literacy rates, low sophistication levels and are from rural background.

Theoretical Considerations

There are many ways in which the factors can be grouped and the area divided into relatively mutually independent and homogenous sets of factors.

A. BROAD GROUPING OF INDICATORS

The factors contributing to the quality of life in families with mentally retarded children, may be broadly classified or considered under two groups:

(a) Those from the points of view of the mental health professionals —These may be called as *satisfactory conditions* and would include such factors as: (i) group cohesiveness in the family, (ii) sharing of each others experiences, (iii) helping attitude towards family members, (iv) understanding and sharing each other's problems, (v) absence of conflicts among members e.g. husband-wife, parents-children, mother-father, among sibs, etc. (vi) absence of mental illness in the family, (vii) absence of any severe or chronic physical illness in the family, (viii) positive and helpful attitude towards the mentally retarded child, etc. These are indicators as observed/inferred by the professionals, with certain expectations from such a family.

(b) Those from the points of view of the mentally retarded child: These may be called as *satisfying conditions* and would include such factors as: (i) a sense of belongingness to the family, (ii) presence of positive attitude towards the family members, (iii) subjective feelings of physical, psychological and social well-being, (iv) absence of unhappy experiences within the family, etc. These are all highly subjective factors.

B. SPECIFIC INDICATORS

(i) *Group cohesiveness* : In a family, members may have different interests, roles, statutes, aspirations, value systems, preoccupations, etc. All these are not undesirable aspects, rather they may add colour, richness and quality to the family life. If inspite of or in the presence of such diversity of interests and aptitudes, they can enjoy some degree of group cohesiveness, a sense of belongingness, togetherness, the quality of the family life would be increased many times. To the extent it can act as a unit, taking group decisions, respecting each other's opinions, interests, and sensitivities, and stick to those collective decisions or goals, particularly in facing life problems and in crisis situations, the family has this desirable quality. Both positive (desirable behaviours) and negative (undesirable behaviours) aspects of it need to be rated in order to assess it in a comprehensive manners.

(ii) *Sharing of experiences*: Other things remaining the same, a family that shares each others experiences may be said to have higher or better quality of life. Sharing of experiences may be both for positive or happy as well as for unhappy experiences. The extent may vary in different members but the overall rating is done rather than a separate one for each member, for it is quality of family life and not of the individual members that is judged. It is expected that by sharing such experiences, happiness increases and/or unhappiness decreases within the family.

(iii) *Helping attitudes among family members*: Presence of cooperation and helping attitude among family members also contributes towards quality of family life. The extent to which it is present without exception in a family, it is rated here. Helping attitudes have to be mutual and does not include one sided dependence upon one or more family members. This is inspite of any handicap or, disability in any one member and emphasis is on coming forward to volunteer help rather than waiting for being asked and taking a long time to decide. Anticipation of each other's need helps.

(iv) *Understanding and sharing each other's problems*: In a family with high quality of life, it is expected that the members not only understand, and appreciate each other's problems and difficulties but also share them. As its direct or indirect result the felt burden or, problems may be decreased. It is considered as a desirable quality and may be present in all families to varying levels. Even if one is not able to share it, the understanding and awareness helps in the international processes within the family and decreases the felt burden in the family.

(v) *Absence of conflicts/quarrels among family members*: The presence of inter-familial and intrafamilial conflicts are likely to lower the quality of family life, whatsoever be the reason and whosoever may be at fault. It is because of this reason that the absence of conflicts/quarrels among family members are considered as one of the contributory factors to the quality of the family life. This however, is different from the conflict of interests—individuals' and families'.

(vi) *Absence of severe mental illness in the family*: There are many ways in which the presence of a mentally ill person may reflect or, add to the problems or conflicts in the family. In reactive mental illnesses, such conflicts may lead on to the precipitation of a mental illness, and may add to them. Attitudes of other members of the family may be adversely affected by the knowledge of a mentally ill person in the family. It may be perceived by some members as on added burden on and increased responsibilities for them. Thus it may not be the presence of mental illness in the family as such but the reactions of individual members of the family which may lead to a reduction in the quality of family life. Absence of mental illness by it self may not add to the quality of life. On the other hand, any predisposition to mental illness may be dormant because of healthy interpersonal relations and emotional support system within the family itself. In such a case, the absence of mental illness in the family could be called as an indicator of quality of family life.

On the other hand, any predisposition to mental illness may be dormant because of healthy interpersonal relations and emotional support system within the family itself. In such a case, the absence of mental illness in the family could be called as an indicator of quality of family life.

(vii) *Absence of serious physical illness in the family*: Absence of physical illness, to the extent it is a result of the mental health status and well being of members of the family, may reflect the quality of family life. Physical illness may be a result of malnutrition (which may itself be due to faulty or, unhealthy food habits, knowledge, practice, customs, etc.), personality disorders. drug and alcohol dependence, indisciplined life as such and other related factors, which may lower the quality of family life. It is not implied here that in a quality home or family, nobody would ever fall sick.

(viii) *Positive and helpful attitude towards the mentally retarded child*: In a family with a mentally retarded child, it is very important to study the attitudes of the other members of the family towards the mentally retarded child. The attitude towards mental retardation itself may not be negative or harmful, so long as it is an abstract concept and distant possibility but having awareness of this handicap in one's family and apprehensions about its real or imagined effects on the life of other members, may adversely affect the quality of family life. It is important to know in such cases how the family perceives this and how it copes with this, in order to correctly assess the quality of family life in such a family.

(ix) *A sense of belongingness to the family*: The quality of family life may also be judged how the mentally retarded child perceived and feels about being in that family. Does he feel accepted, understood, or, pitied ignored or rejected and denied most privileges given to other family members ? His own sense of belongingness to the family may be a good indicator of the quality of family life. It is as important to know how he relates to and feels about it as it is how he is treated by others in the family, if not more important.

(x) *Presence of positive attitudes towards the family members*: Belongingness may not always be a direct result of good treatment in the family. It may, on the other hand, be present even if the person may be maltreated as it reflects his feelings and attitudes and not the family members. The belongingness may be absent, yet the mentally retarded child may have positive attitudes towards some of the family members if not towards all. This in itself may indicate high quality of family life. He may not feel one, or see eye to eye with other members of the family, may have poor sense of belongingness after knowing their negative attitudes towards himself, but all the same, unreasonable as it may sound to others, may have nothing but good fellow feelings. Intelligence, fortunately, is no bar to good fellow feelings and positive attitudes. He may unwillingly blame himself for not being able to come to other's expectations.

(xi) *Subjective feelings of physical, psychological and social well-being*: Quality of family life is indicated by the extent to which each individual member, in spite of his own health status, feels wanted accepted, and has satisfying feelings of own physical, psychological and social existence in the family. This may be purely a subjective feelings, but its presence is important. It is implied here that this feeling may be at times independent of the actual, objective health, mental or social status. One may still be zealous, discontended and ill at ease with himself and with others, inspite of a high status with all the powers of decision making in the family. Being at peace with oneself and with others is a positive attribute.

(xii) *Absence of unhappy experiences in the family*: Unhappy interpersonal interactions within the family, may be quite bitter and longlasting, at times at least. Some of these may be particularly severe and always pricking the mind of mentally retarded child. He may become fearful, apprehensive and withdrawn. Such unhappy experiences are unlikely to contribute to the quality of family life. It is not necessary that these experiences may always remain unresolved or, that their absence would necessarily lead to high quality of family life. But on the whole, and other things remaining the same, it is desirable if there are no such unhappy experiences that may come in the way of enjoying the life experiences in future. To that extent their absence may be considered as contributing to the quality of family life.

The Problems in Measurement

These are only some of the indicators of quality of family life in families with a mentally retarted child. There may be many others that need to be identified and some of these described above may not be mutually independent. They may be contributing to the totality of the concept of quality of family life in different proportions. In fact, it may come out that the quality of family life is not a unitary concept but there are a group of independent factors that need to be considered. These and other issues can be explored, studied and measured reliably only through systematic experimentation. No amount of armchair speculation alone would be able to provide a satisfactory answer to these.

A Rating scale or questionnaire can be prepared to measure this quality of family life. The items have to be simple, brief, and easily understood by majority of our population which is rural, low in literacy/illiterate and unsophisticated in the use of such instruments.

Such a measuring tool is likely to be influenced by certain response biases. For example, there might be a tendency to agree (Yea Saying) or, tendency to give a socially desirable response in place of a true one, or to choose a particular response category (e.g.) the first response alternative, the middle most replies or the avoidance of extreme categories, etc.). There is a need to look into these possible sources of biases in the questionnaire, before putting them up for reliability, validity or normative studies.

The questions may be put in simple, brief language, that avoids difficult words and are not to complicated too long. The "underlining test" can be tried in order to find out the "difficult words". Some of the items may be put in negative form, but with care that it may not become complicated and confusing for the subjects. If three response categories are to be effectively utilized, it may be more useful if five response categories are actually used. The tool may be administered under "standard instructions" and "foke good" response instructions, in order to find out possible effect of social desirability response set. For this, correlation of the items and of the tool with the lie on Social Desirability Scale may also be calculated. These are some of the steps that are necessary particularly for such a scale which is likely to be effected by such response biases.

Test-retest and inter-rater reliabilities need to be established. The interval for retest need not be very long and may be as short as day, as there are no right or, wrong responses or any likely lerrning or memory effect. Split half reliabilities may also be established.

Factor analysis can also be done or elementary linkage analysis to see the clustering. In addition, the responses may be validated against external criterion like, subjective well being of individual members in extreme families that could be easily identified. Families in which the mentally retarted children have emotional problems may be compared with those where mentally retarted children are relatively free from it. For validational purposes, degree of mental retardation, socio-economic status of the families, etc. need also be considered. The quality of Family Life Scale or Questionnaire thus constructed should also show low/insignificant co-relations with such personality factors like neuroticism, psychoticism, paranoid, depressive, anxiety and other such pathological states. ☐

BIBLIOGRAPHY

1. Blan, T.H, (1977) Quality of life, social indicators and criteria of change, Professional Psychology, 8, 464-473.

2. Campbell, A. (1976) Subjective measures of well being, Amer. Psychol. 31, 117-124.

3. Dupuy, H.J. (1970) Development of rationale, substantive, derivative and conceptual relevance of the General Well Being Schedule, Unpublished Working Paper.

4. Fazio, A.F. (1977) A concurrent validational study of NCHS General Well Being Schedule, Series 2 Number 73 US Dept. of Health, Education and Welfare.

5. Flanagan, J.C. (1982) Measurent of quality of life: Current State of the Art. Archives of Physical Medicine and Rehabilitation, 63, 56-59.

6. Nagpal, R. and Sell, H. (1985) Subjective well being, SEARO Regional Health Papers No. 7. WHO, SEARO, New Delhi.

7. National Mental Health Programme for India (1982) DGHS, New Delhi.

8. SEARO (1984) Indicators of Mental Health. Report on a WHO/UNICEF Inter-Country Workshop. SE/Ment/79.

9. Sharma, S.D. (1985) Poverty, health and quality of life. Presidential Address, 37th Annual Conference of Indian Psychiatric Society, Visakhapatnam.

10. Verma, S.K. Dubey, B.L. and Gupta, D. (1983) PGI General Well being Scale –some correlates. Indian Journal of Clinical Psychology, 10, 299-304.

11. WHO (1981) Development of Indicators of Monitoring progress health for all. Health for All Series No. 4.

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HEALTH POLICY : ETHICS & HUMAN VALUES NEW DELHI 1986

Health Problems of the Aged Persons and Their Place in Drawing up Health Policy in Our Country

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All over the World the people are living longer and this is specially seen in the developed countries where the group of elderly from 60 years of age onwards is increasing. This may range from 1/7th to 1/6th of the population which means that every 6th or 7th person belongs to this category of elderly. It is normal for them to live up to the age of 70 or 75 and lead a useful life. With the introduction and development of geriatric medicine for treatment and management of aged and specially its preventive aspect, this age group is rapidly advancing and it is not unusual to see persons of 80 years or above in a healthy state.

Of course the problems of these aged persons cover a wide range from medical and health to social, familial, financial and maladjustment problems and these are to be tackled with sympathy and patience. Large sum of money is required to be spent on the care of the aged and it is said that for the care and management of an average elderly patient about 2½ to 3 times the amount of money is required as compared to an average younger patient and the average stay of the elderly in hospital is also proportionately much more. In the developed countries all these problems of the elderly are well recognised and they are being treated and managed by qualified physicians in Geriatric Medicine and in institutions which have geriatric medicine wards. In U. K. alone there are at present about 270 departments of Geriatric Medicine and each providing a district service which includes not only treatment of acute illness but rehabilitation of persons with disabilities. Of course each institutional service may vary in various units depending on resources and other allied factors. Besides training and education of medical officers and medical students in medical and health problems of the aged, even the members of the health team such as nurses, social workers and paramedical staff are also trained in health problems of the aged. Even the general public is made aware of the problem of the aged so as to receive their cooperation.

The aim is to provide service and tackle problems of the elderly to enable them to live as long as is possible in an optimum state of health in their homes, preferably with their families if possible.

In India so far no concerted efforts have been made to tackle the medical and health problems of the aged by a specialised group of doctors trained in Geriatric Medicine and hence it has not been possible to give proper attention and care to the varied problems of aged. Even the general public has very little awarness of it.

Only during the last few years a few voluntary agencies are taking interest in the problems of the aged and one or two medical societies have also started working for solving the health problems of the aged. A Symposium on "Hormones and Aging" was recently conducted under the auspices of Geriatric Society of India at the All India Institute of Medical Sciences and even this prestigious Medical Institute of our country has no separate department of Geriatric Medicine and no separate out patient department for treatment of the old as far as my information goes. Such a state of affairs exist all over India and the health problems of the aged have received no particular attention.

The problems of the aged are manifold and cover a wide range from medical and health to social, familial and financial and other allied factors affecting the aged but in this lecture of mine I shall largely dwelve upon health and social problems.

The health problems may be multifactorial and multidimensional. It is not unusual for an elderly to suffer from more than one disease. Infact in many cases they may be suffering from 2 or 3 diseases or more and more than one system may be involved. Not only that, but even the symptomatology and presentation of the disease may be slightly different, for instance in some acute illness, there may be absence of fever and in some cases of myocardial infarction there may be absence of chest pain. Multiple pathology is the rule rather than the exception with an elderly and quiet, a typical presentation of illness is commonly seen in and elderly. Even the prognosis in some of these cases in difficult to assess. Hence it is very important that there must be proper training of a medical student at an undergraduate level and a doctor at a postgraduate level under a competent specialist of geriatric medicine.

There are very few diseases which are solely confined to aged people. Polymyalgia rheumatica[2] is one such disease. Diseases like Parkinsonism occurs more often in elderly but may effect comparatively at early age also and here the aetiology may be different.

Every system may thus be affected but the presentation of the disease may be slightly modified or altered due to poor reserve capacity, increasing immobility or unsteadiness, Mental incompetence and impaired haemostasis. Incontinence of urine and/or faeces is another factor which needs investigation. Psychological factors and specially mental depression leading on to senile dementia may play an important part in the health problem of the elderly. Relationship of various hormones in health, disease and aging is now increasingly established and should therefore be thoroughly investigated and tackled.

Hence the complete evaluation of the elderly patient by a competent doctor trained in geriatric medicine is essential and his various systems should be thoroughly examined with sympathy and patience and the doctor may also interrogate the close relations of the patient's family. While investigating the patient, and assessment of the economic and social circumstances is an important part of evaluation.[3]

In India, the joint family system which existed from olden times, is now slowly crumbling down and there is need to emphasise it if possible or find an effective alternative system of rehabilitation of the elderly.

By the turn of this century, this increasing population of the elderly may account for 1/10th to 1/7th of the total population which means we may have about 10 to 12 crores of people above the age of 55 years onwards in our country by the year 2000.

If therefore the Alma Ata declaration of W.H.O. "Health for all by year 2000" is to be achieved, this large section of our population has to be looked after. It is time that necessary step are to be taken now in starting to tackle the multifarious health problems of the aged. Some of these steps may be mentioned as under.

(1) Geriatric Medicine must be recognised as a separate discipline and a subspecially of medicine which eventually may be put in the same category as Paediatric Medicine as an independent Medicine discipline at it gradually develops.

(2) Teaching of Geriatric Medicine both at the undergraduate and postgraduate levels be started in every major medical teaching institution.

(3) Special geriatric medicine wards are to be opened in every major hospital in the century and in every medical teaching.

(4) Besides imparting training to undergraduate in the subject of geriatric medicine, 9 months to one year's diploma course may also be started for doctors in geriatric medicine and M.D. in geriatric medicine may also be started in some postgraduate medical teaching institution under qualified specialists in geriatric medicine.

(5) To start with effective steps to be taken initially for the training of doctors in this subject; along with members of health team like nurses, paramedical staff and even social workers.

(6) Some senior physicians to be deputed to Western countries like U.K., U.S.A., Soviet Union etc. to familiarise and get acquainted with the progress made in the teaching of the subject and the kind of health care and management given to old patients.

(7) A centre of Gerontology for research work in the problem of aging be set up in our country also specially in two or three postgraduate medical institutions of which perhaps one may be set up in Delhi immediately in the A.I.I.M.S. with cooperation of I.C.M.R.

(8) One or two separate hospitals for geriatric patients if not possible

at present may be conceived in the long run and specially one may be established in Delhi.

(9) Since voluntary agencies will be playing an increasing role in the tackling of non-medical problems, social and other factors affecting the aged and their role is very important in giving comfort and security to the aged, their cooperation is most essential and they should be given proper recognition together with education and guidance in starting short training courses regarding the problems of the aged.

The general public should also be made aware of the problems of the aged in order to secure their understanding and cooperation.

Hence, in the end one may sum up that in drawing up the health policy of our country, this increasingly large section of our population and their problems—specially their health problems must be tackled properly, effectively and in a scientific manner.

Then alone we shall be able to cover all the sections of our population regarding their health problems and this will be one more positive step towards achieving the W.H.O. goal of Health for All by the year 2000.

Last of all one may summarise that in this limited time it has not been possible to give detailed information of various health problems except that an attempt has been made to highlight the significance of this subject as, so far, no attempt has been made in our country to tackle these problems methodically, systematically and scientifically. It is therefore time to emphasize that problem and tackle it in a systematic matter as is done in the developed countries of the West. ☐

References

(1) Keith Andrews, J.C. Brocklehurst : A profile of Creative Rehabilitation Units; Journal of the Royal College of Physicians, London, Vol. 19, No. 4, Oct., 1985.

(2) William Ferguson Anderson : Advances in Education, "Geriatric Medicine, by W.F. Anderson & T.G. Juge, 1974.

(3) William R. Hizzard : Leading the Health Care Team for the Elderly; Harrison's Principles of Internal Medicine", 10th Ed.

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Care of Infants and Women

(Including Hereditary Diseases)

Dr. K. Indirabai

Introduction

Inspite of advances made in medical technology and the enormous amount of money spent on health care, 80-85% of the under-priviledged and vulnerable section of our population which includes infants and women still do not have access to basic health services.

Many families which are often large, exists in a state of partial starvation; and the mothers usually consume about 1600 calories/ day and produce low birth weight babies who contribute to the high perinatal and infant mortality rates.

In addition, the high incidence of intrauterine, neonatal, and postnatal malnutrition leads not only to high infant mortality rates but also to poor physical growth, premature senility, and low life expectancy among those who survive beyond infancy. It had adverse effects on mental development that result in reduced mental and physical potential and impose a serious handicap on economic development in all fields, particularly in agriculture and industry. This cycle of events also cripple the social and cultural advancement of the communities.

Poor nutrition, lack of sanitation, poor hygiene, and inadequate immunizations result in high incidence of communicable diseases like gastro-enteritis, respiratory-infections, tuberculosis, measles, whooping cough, diphtheria, polio myelitis and other bacterial, viral, and parasitic infections and thus ill health continues to be the way of life in such families.

Seventy to 80% of the inhabitants in the under-privileged communities are illiterate because of the poor educational facitities.

Due to population growth the services rendered are getting diluted and IMR continues to be very high i.e., 114/1000 L.B.

Care of Infants

Every child born has a right to live and lead a healthy life.

If we go by the statement of James P. Grant (1), the Executive Director of UNICEF, on the state of world's children, it looks that we may not be able to achieve Health for All and reduce our infant mortality rate (IMR) to less than 60/1000 by 2000 A.D. as per Alma-Ata Declaration.

The challenge of reducing the high IMR in our country is not the only problem but it is also a question of survival that these infants face entering the world.

The medical profession including pediatricians has major role to play, apart from other agencies.

The highly ambitious 7th Five Year Plan has been launched under the stewardship of our dynamic; action oriented Honorable Prime Minister Shri Rajiv Gandhi. This plan distinguished itself from the earlier ones in several respects. An accountability has been introduced by setting targets on reduction of maternal and childhood mortality, low birth-weight prevalence and achieving 85-100% coverage for immunisation. Separate allocations have been made for the first time for the care of new born and for creation of the first national Institute of Maternal and Child Health.

The government of India has rightly considered the influence of mortality on birth rates and it has planned to decrease the Infant Mortality Rate from the current 114 to 87/1000, and PNMR from 60-80 to 40 by the end of the Plan.

Here comes our most important role i.e. if we assure the survival of the existing children by taking proper care, the parents will certainly limit their families.

The problem of reducing IMR is complex and an effective and sustained decline can only be achieved by a multi-pronged approach aimed at resolving social, ecological, educational, public health and environmental problems. As has been shown by the experience of Kerala, female literacy, spacing of births and easy access to health facilities, whether Government or non-Government, are the main determinants of Infant Mortality Rate.

The extremely high and unchanging maternal, perinatal and neonatal mortality rates are not surprising. The antenatal clinics and delivery rooms remain overcrowded, understaffed and inadequately or poorly equipped.

A newborn is considered a mere appendage of the mother and inspite of the recommendations of the Central Health Council, it has not been given the status of a hospital bed. The training and education in perinatology and neonatology of the primary health care workers, nursing and medical undergraduate and postgraduate students is not only inadequate but ignores essentials such as 'at risk approach' resuscitation of the new born and so forth. The poorly provided or equipped facilities for primary, secondary and tertiary contributes to poor knowledge and acquisition of skills by health professionals.

The government of India has indeed recognised these problems and constituted a task force to define the minimum needs for quality oriented perinatal and neonatal care in terms of physical space, man-power, equipment, education and training at various levels of health care, and we fondly hope that they will be implemented soon without further delay.

It is true that it may not be possible to create new programmes due to financial constraints, but the existing National Integrated Child Development Services and post partum programmes can be effectively modified or expanded to include perinatal and neonatal care. The post partum programme is hospital and urban based and the ICDS a community based programme. Both the programmes deal with parturient mother and ICDS has a strong component of child care beyond 6 months. Strengthening of these programmes with manpower, material, supplies and structural facilities for improving and providing neonatal care will certainly make this a very efficient and effective family welfare programme and it is necessary to integrate the services of the Obstetricians so that together we can improve not only the survival but also the quality of life of mother and her off-spring.

The urgency of controlling preventable infectious diseases, and malnutrition has already been realized by the Government and an extension of the ICDS programme to 3000 blocks was dedicated with its emphasis on growth monitoring, inclusion of measels immunization in Expanded Programme of Immunization (EPI) and with the adoption of strategies such as universalization of immunization. Oral rehydration for controlling deaths due to diarrhoea and looking into the possibility of the treatment of acute respiratory infections by primary health care workers, all are steps in the right direction.

The plan of universalisation of immunization is a good strategy for covering the gap that exists today between the actual immunisation coverage and the goals to be achieved by the end of the decade.

Immunization has to be provided continuously and can succeed only if the community becomes aware of it and seeks immunisation. While one can with efforts achieve 100% coverage for a population by mass programmes, the entire strategy may fail if continuity and surveillance of diseases is not maintained.

Care of Women

"The cumulative result of poverty, under-nutrition and neglect which girls suffer right from birth is reflected in their poor adult today size, which in turn influences high maternal mortality, low birth weight and poor nutritional status of their infants. The relative neglect of the female child is evident from the greater prevalence of growth retardation even in the infancy among girls than in boys. . .".

The greatest of those difficulties is the fact that the majority of the developing world's women have to large a share of responsibility for family well-being and too small a share in the decisions which affect it.

For whether we are talking about breast-feeding or weaning, oral rehydration therapy or immunization, regular growth checking or frequent handwashing, it is obvious that the mother stands right at the centre of this programme.

Hence it is our responsibility to protect and improve the lives of women.

Many millions of the world's women are permanently in poor health.

The cause is not usually a specific illness. It is rather the general 'maternal depletion' caused by too much work and too little food combined with too many pregnancies to close together.

Family spacing : Leaving at least two years between one pregnancy and the next can reduce the risk of an infant's death by 50% or more. But it is also the most important way, of maintaining the health of those whose bodies are depleted by the heavy nutritional stresses of almost continuous pregnancy' child-bearing, and breast-feeding. In most developing countries, 'maternal causes' are the leading cause of death for women between the ages of 25 and 35. In other words, more than a thousand young mothers are now dying everyday—and many of those 'maternal deaths' are the result of too many births too close together.

Female education : The education of the mother has been found to be perhaps the most important social determinant and also is a powerful force for improving the lives of mothers themselves.

Food supplements : A relatively small amount of extra food each day, for at-risk pregnant woman, has been shown to reduce the incidence of low birth-weight which is "universally and in all population groups, the single most important determinant of the chances of the new born to survive and to experience healthy growth and development." Similarly, extra food for breast-feeding women can mean more successful and longer lactation.

Hereditary Diseases

Hereditary diseases have grown into hundreds and are being discovered at an ever-increasing rate and majority of them are due to inborn errors of metabolism i.e. Albinism, Phenyl Ketonuria. Wilson's disease, etc.

At this juncture, genetic counselling comes into the picture. Genetic counselling is a process of communication dealing with the human problems associated with the awareness or risk of awareness of a genetic disorder in a family. The first step in genetic counselling is to make certain that the diagnosis is correct. Those who receive it can be divided into a majority who are unaware of their risks and a minority who request genetic information and counselling. The latter most commonly are couples whose first child has just been born with a birth defect or medical problem. Others seek information prior to marriage or before having children because of medical problems of their relatives.

The challenge for the physician is to recognise which birth defects and medical problems are hereditary and to offer genetic information to all families, not just to those who request it.

Parents may assume, that a problem can't be hereditary if no other relatives are affected. This issue has to be discussed in great detail and it is necessary to impress upon the couple that a child with hereditary disorder can be born to healthy parents with no affected relatives. □

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Leprosy Eradication Programme in India —an Over-view

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Leprosy is foremost public health problem in India with far-reaching social implications. It is estimated that of the 12 million cases in the world, India accounts for nearly 4 million. 20% of the cases occur in children; and nearly 15 to 20% suffer from disabilities. About 20% of the cases are infectious.

Case load

The first survey for leprosy in the country was made as part of British Imperial Census in the year 1971-72. The extent of the disease was subsequently reviewed by the British Leprosy Commission in 1890-91. The prevalence rate of leprosy during the period prior to 1950 was essentially obtained as part of the decennial population census. However, there are reasons to believe that the disease was grossly under estimated. Only advanced forms of cases were included in the census and not all cases were reported because of social stigma attached to the disease. Further patients with minor symptoms were not recognised. The estimated number of leprosy patients in 1951 was 1.3 million while in 1981 the figure was 3.9 millions. There has been a consistant increase in the estimated cases over the years accounted for by an increase in the population as also extension of surveys to newer areas.

Considerable inter-state variations occur in the prevalence rate of leprosy in the various States and UTs. The greatest case load of leprosy falls on the Eastern belt of the country comprising Andhra Pradesh, Tamil Nadu, Orissa and West Bengal; these States sharing almost 53% of the estimated case load.

National Leprosy Eradication Programme

The National Leprosy Eradication Programme made its beginning in 1955 as a Centrally Aided Scheme with its focus primarily on rural areas of high and moderate endemicity. In the low endemic States the expectation was that leposy services can be provided through existing health care facilities. In the beginning the programme did not have clearly defined operational objectives. Only the problem was identified and inputs provided for its strengthening. Thus for nearly two decades it remained an input-oriented programme. This was due to several factors:

(i) absence of any primary preventive measures (vaccine) and non-cultivability of leprosy bacilli;

(ii) non-availability of potent drugs for quick and complete cure;

(*iii*) isolation of all the cases was not feasible as benefits were not commensurate with costs involved; and

(iv) the population was not fully cooperative due to social stigma attached to the disease.

It was only in 1976 that the programme was made performance oriented, giving each State targets by the Government of India for detection of new cases, for cases to be brought under treatment and also the number of patients to be discharged after disease was arrested.

Strategy

The main strategy of the programme is to control the disease through reduction in the quantum of infection in the population, reduction of infective sources and thus breaking the chain of disease transmission. Four basic activities were envisaged viz;

(i) Survey and case detection;

(ii) Registration of cases for treatment;

(iii) Provision of continous treatment with sulphones to all cases; and

(iv) Education of the patients, their families and the community at large about leprosy.

Recently with the discovery of a number of highly effective bactericidal drugs, substantial reduction in disease incidence in the near future, appear feasible. The Government of India in 1982 decided to introduce Multi Drug Treatment to cover all the cases in a phased manner, starting with districts where endemicity of the disease was more than 10 per 1000 population. It is expected that with the necessary provision of infrastructure required for MDT, it would be possible to cover all the endemic districts within the next 10 years.

Infrastructure

The programme extends to rural as well as urban areas. Anti leprosy activites fan out from leprosy control units and Survey Education and Treatment Centres in the rural areas and from urban leprosy centres to the urban population. The total coverage extends to nearly 43 crores people. Important administrative measures have been undertaken following recommendations of the Swaminathan Committee to make leprosy eradication a time-bound programme by the turn of the century. A National Leprosy Eradication Commission functions under the Chairmanship of the Union Minister for Health & F.W. with several Chief Ministers from States and UTs as its members for laying down policies and provide guidance. The National Leprosy Eradication Board under the Chairmanship of Union Health Secretary reviews periodically the implementation of the activities related to the programme.

Training of personnel

National Leprosy Eradication Programme is a vertical programme and therefore, has its own requirements of trained personnel at various levels. Forty three Leprosy Training Centres function in the country for training of Para Medical Workers, Non-Medical Supervisors, Physiotherapists, Laboratory Technicians, Medical Officers, etc. working for the programme.

Expenditure

Leprosy is recognised as a high priority area for assistance by the Government of India and forms a part of 20-point programme. The concern of the Govt. of India and its political commitment for leprosy eradication are borne out by the fact that there has been nearly a two-fold rise in the financial outlay for the programme—from Rs. 202.30 million in 1974-79 to Rs. 412.00 million in 1980-85 and Rs. 650.00 million in 1985-90.

Health Education

There is no doubt that a change in the image of leprosy in the minds of people would in itself be a great factor in promoting anti leprosy activities. For this reason lack of awareness on scientific facts about its causation, complete curability of leposy and to dispel prevalent prejudices and misconceptions about the disease form the main thrust of health education campaign as an integral part of the programme.

Rehabilitation

Facilities for vocational and social rehabilitation of deformed cured leprosy patients have been created and are operated by several philanthropic organisations/individuals. Medical rehabilitation of the deformed patients is supported under the programme through 75 Reconstructive Surgery Units and Leprosy Rehabilitation Promotion Units. Plans are underway for stimulating vocational rehabilitation of patients in their homes/communities.

Voluntary Organisations

The voluntary organisation had been playing a poineering role in leprosy work in India eversince the first known leprosy asylum was established in Calcutta in the early 19th century. Over 100 organisations are involved in various activities pertaining to control of leprosy in India, including training of personnel, education and research in addition to case detection, treatment and rehabilitation. The Government of India have a scheme for financial assistance to these organisations.

Case detection and treatment

The recorded evidence indicate that the performance of the National Leprosy Control Programme during the last three decades of its existence has been commendable. There were estimated 3.95 million cases of leprosy in India in 1981 out of which 2.58 million were reported to have been detected by December, 1980. Recently there has been a remarkable increase in case detection during the 6th plan period accounting for 41.5% of total case detection so far.

As on 31.3.85 i.e. at the end of 6th plan period, 3.27 million leprosy cases were on records and 3.05 million of them under dapsone treatment. Over 95% of the cases are receiving the drugs in their houses. The number of leprosy cases discharged due to cure or death from the inception of the programme stood at 1.93 million. At the end of December, 1985, 3.33 million cases were on record with 3.09 million receiving treatment. During the 9 month period between April and December, 1985, 0.31 million more cases have been discharged making the total number of cases discharged since inception as 2.21 millions.

Multi drug Treatment (MDT) has been introduced in a phased manner since 1982 is selected districts of high endemicity. Currently, 15 of these districts with a population of 37.0 million and having 0.328 million cases are under MDT for periods varying from 3 months to 3 years. The multi drug therapy covered only the multi bacillary cases until June, 1984. Thereafter both multi bacillary and pauci bacillary cases have been brought under MDT. Available information on 6 of the districts where MDT activities have been in progress for more than 2 years are summarised hereunder. Twenty two per cent of the 83,300 new cases detected are multi bacillary. Childhood leprosy accounts for 8% in the multi bacillary group and 20% in pauci bacillary cases. The deformity rates in the new multi bacillary cases and pauci bacillary cases were 20.8% and 6.5% respectively. More than 90% of all cases put under MDT are taking treatment regularly. Drug reactions were observed in 4% of multi bacillary cases and only 0.5% of pauci bacillary type. The reactions were mostly mild. Over 80 per cent of the multi bacillary cases who received the prescribed course have been declared cured.

Monitoring and evaluation

The progress of activities under the programme is monitored through periodic reports from districts to States and States send them to the Central headquarters of the programme in the Directorate General of Health Services. The National Leprosy Eradication Commission meets periodically to formulate policies after review. National Leprosy Eradication Board meets twice a year to evaluate the implementation of the programme. Similar Committees constituted at the State level are also functioning to monitor the programme activities in the States.

An independent evaluation of the programme has been under taken for the first time jointly by the Government of India and WHO between 17th and 28th February, 1986. The report is under preparation. ☐

2.5

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An Analysis of Twenty Three Thousand Laparoscopics

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Endoscopy was started at Medical College hospital Kottayam from 1981. Both diagnostic as well as operative laparoscopy are being done. All diagnostic laparoscopics are done in the hospital where as majority of the laparoscopic sterilization are done in camps arranged at the Primary Health Centres, Taluk Head Quarters and District hospitals.

Laparoscopic sterilization in camps	—/9,822
Laparoscopic sterilization at Medical College, Hospital	—2,850
Diagnostic laparoscopy at Medical College Hospital	— 450
	23,112

Technique of Laparoscopy

All the cases in this series was done by the single puncture technique. under local anaesthesia with premedication. Pneumoperitoneum was created in all cases using air, since cautery is not used in any one. Minimum air is introduced before the introduction of trocar and supplemented if necessary through the laparoscope Sterilization is done in all cases by Falope ring application.

Diagnostic laparoscopy was done for

1. Investigation of Infertility
2. Primary amenorrhoea
3. Suspected ectopic
4. Suspected adnexal masses.
5. Evaluation of the tube for recanalisation following sterilization.

In cases of infertility laparoscopy was done along with Hysterosalpingography Chromotubetion was done in all cases.

Analysis of infertility	
Total number of cases	—325
Tubal block	— 24
Peritubal adhesion	— 32
Endometriosis	— 46
Fibroid Uterus	— 42
Polycystic ovaries	— 4
Congenital abnormalities	— 12

In majority of cases laparoscopy and H.S.S. were tallying. In five cases where laparoscopy showed blocked tubes, tubes were found to be patent on HSS. which was proved at laparotomy later. Peritubal adhesions are visible very clearly especially adhesion with minimal endometriosis. The incidence of endometriosis is in the increase. Among Primary amenorrhoea case—23

Congenital abnormalities of various types were seen.

Absence of Uterus—in six

Various stages of the development of Mullerian ducts could be seen.

Laparoscopy was done in 5 cases of suspected ectopic and confirmed in three.

Small ovarian tumours which could not be diagnosed otherwise were diagnosed in 5 cases.

Complications : encountered during laparoscopy were either due to premedication and anaesthesia or due to laparoscopy itself.

Respiratory arrest occurred in four—all of them were revived.

Skin rushes occurred due to Pethidine in 15 cases.

There was no reaction to localanaesthesia since sensitivity to xylocaine was tested before the procedure.

Creation of pneumo peritoneum was difficult due to obesity in two cases. Parietal emphysema occurred in 123 cases and in two of the cases of laparoscopic Sterilization it was difficult to visualise the tubes due to the large parietal emphysema. Omental emphysema occurred in 7 cases.

During application of Falope rings tearing of tubes occurred in 202 case. In 16 others separate rings had to be applied at the cut end which was outside the ring. Haematoma of the broad ligament by the tongs of the ring applicater occurred in 2 cases in the initial series. Perforation of the uterus by the uterine sound is the most common complication during the procedure since the uterus in our series is manipulated by the sound to view the tubes, ovaries and fouch of Doughas. Perforation occurred in 512 cases but in all cases the bleeding from the site of perforation stopped immediately after withdrawal of the sound and did not require laparotomy in any one. Omental herniation with withdrawal of trocar was prevent in 26 and omentum was immediately pushed back and wound sutured only in one case introperitoneal haemerrhage took place from the site of introduction of the scope that is at the umbilicus and she was operated upon next day and bleeding controlled. There were no cases of death is the series.

Failure of laproscopic, sterilization in our series is less than 1 in 1000. That is 19 cases out of 22,672 sterilization. In 10, cases re-laparoscopic sterilization was done with M.T.P. Minilap. with M.T.P. in 5 and four cases went to term and delivered. On relaparoscopy and minilap., the failure in most of the cases was found to be due to slipping of the falope ring so that the whole lumen was not occluded. In two the rings were absent on one of the tubes.

Patients have come back also requesting for recanalisation operation on death of one of their children since majority are done after two deliveries. Recanalisation was done in three and two of them have give to term and delivered one had normal labour and the other a caesarean section.

With the popularisation of laparoscopic sterilization the number of multiparas—four and above have almost become a rarity and our maternal mortality from complications of multiparity has reduced tremendously. Diagnostic laparoscopy has given an opportunity to make a clear pre-operative evaluation of infertility cases with the facility of planning the operation. It has also made it easy for diagnosis of endometriosis and P.T.D. without laparotomy and also for evaluation of past operative cases. □

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Tuberculosis—Yesterday, To-Day & To-Morrow

Is Control Possible by 2000 AD Under Existing Health Policy?

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Tuberculosis is a specific communicable disease caused by a tiny germ, tubercle bacillus. Among its victims were Kamla Nehru, Subhash Chander Bose and Govind Vallabh Pant. Inspite of the fact that highly effective vaccine and drugs have deen available for more than 30 years, making TB a preventable and curable disease, the total number of cases of tuberculosis has increased in India (Table I). *It is believed that in our country, 50% of the world tuberculosis population resides*[1,2]. At present, TB still remains the scandal of a disease[3] which continues to be a major community health hazard in our country, next most dangerous after malaria[4].

National Tuberculosis Control Programme (NTCP)

NTCP was launched in 1962 as an organised effort to bring under control the problem of tuberculosis in the entire country, with the following operational objectives :—

(i) To vaccinate with BCG a majority of the eligibles (if possible more than 70% in the community, in an efficient manner).

(ii) To detect maximun number of TB patients amongst out-patients attending health institutions with symptoms and to treat efficiently; in doing so, give priority to sputum positive TB patients.

(iii) To undertake the above activities from all the health institutions as an integral part of the general health services[5].

Dr. piot, a WHO Medical Officer in 1962 defined tuberculosis control as the reduction over a span of years of the problem of tuberculosis as expressed by the prevalence of the disease. A reasonable target for control, he said, might be a 50% reduction in the prevalence of excretors of tubercle bacilli over a period of 20 years[6]. However, according to WHO, tuberculosis 'control' is achieved when the prevalence of natural reactors to standard tuberculin among children in the 14 years age group is less than one per cent[7]. In India, it is more than 30 per cent[8]. "Our ultimate objective is the conquest of tuberculosis if not eradication by the end of the 5th plan period", declared Dr. K. N. Rao in 1966, the then Director-General of Health Services, Government of India[9].

NTCP & DTCP : Shortfalls During 1962—82

The District Tuberculosis Control Programme (DTCP) was evolved by the National Tuberculosis Institute, Bangalore in 1962 to be the basic unit of NTCP[10]. Applying the National Survey findings, the different areas of an average district contain TB patients as detailed in Table II.

Estimates of the overall level of success and shortfall have been made by different workers. It was reported by Banerjee[11] that after more than 10 years of work (1962—72) less than 25% of TB patients were brought within the purview of the NTCP; more than 75% of the patients continued to suffer and spread the disease in the community. While reviewing the achievements of DTCP in 1974 in a symposium on NTCP[12] the programme efficiency was reported at 30% and shortfall of 70%. *If the average shortfall was* 70% *in* 1974, *it had gone upto in* 82% 1982[13] *and* 92% *in* 1983.[14]

The three main components of the tuberculosis treatment programme are case-finding, case-holding and chemotherapy, and their efficiencies at the moment are estimated to be app. 33%, 35% and 75% respectively[14]. From this follows that less than 8% of the tuberculosis patients in the community are being successfully treated (Table IV).

Quarterly progress report of the DTCP for the period ending December, 1980 issued by the Director-General of Health Services, Government of India, New Delhi showed a disturbing feature that Peripheral Health Institutions contributed only 35.9% of the total infectious cases instead of the expected 80%[15].

A study on tuberculosis, conducted for a period of 20 years in New Delhi Tuberculosis Centre, (1962-82) did not reveal any appreciable change in respect of any important epidemiological index[16]. These findings have also been confirmed by studies from other parts of the country. In another study conducted in a pediatric hospital in Delhi during 1983, out of 175 consecutive children suffering from tuberculosis 86.3% did not have any BCG scar, and the vaccination was not effective in the rest 13.7% woh had BCG scar : it meant a 100% failure of the BCG vaccination programme)[17].

Extent of TB Problem in the Country 1961—81

It is obvious from Table I (column C & D) that if the population of India increased from about 439.23 million in 1961 to over 685.18 million in 1981, the number of radiological disease and infectious disease patients has also increased proportionately. Whereas, in 1961 about 368960 Indians used to die of TB every year, now the number is more than 575560. *It meant that on an average, over forty eight thousand patients died of TB every month in India in* 1981.

Situation in 1986

At present, with an app. population of 765.81 million people, India is likely to have a total of 14.55 million TB patients including 3.06 million infectious to their fellow citizens. In addition, TB is likely to claim the lives of more than 640,000 Indians every year, 53,000 every month, 13,000 every week, 1700 every day, 70 every hour and more than one Indian every minute. Death from tuberculosis brings shame to our society and to the community of nations (Styblo) (18).

The direct and indirect cost of TB affecting 6.8 million persons was calculated to be over Rs. 20,000/- million in 1966 by Dr. K. N. Rao, the then Director-General of Health Services, Government of India. With rising cost of living, and the projected number of TB patients approximating 20 million in the year 2001, the lose to the nation is going to be colossal.

Whether we take Dr. Piot or W.H.O.'s criteria, our NTCP & DTCP have failed on all operational objectives. What to say of conquering TB by 1978 as declared by Dr. Rao, a former Director-General of Health Services, we have not been able to make in 1986, even a dent in the enemy territory, inspite of the fact that we have highly effective drugs and BCG vaccine, and over 110,478 health institutions, including 13,276 for TB control work (Table III). Tuberculosis population is increasing in our country. Why this whittling down of achievements ? Why this shortfall ?

It appears that National Tuberculosis Control Programme is a programme managed by people who have nothing to do, but watch other people who are doing nothing. National Tuberculosis Control Programme or District Tuberculosis Control Programme is dangerous in untrained hands and waste in over-trained hands.

Problem Likely in the Year 2001 AD

It appears that if no adequate and effective control measures are taken, then, in the year 2001 AD, India may have nearly twenty million TB patients out of which over 4.21 million would be spreading infection to their fellow Indians. Not only this, nearly 0.88 million are likely to die every year from 2001 AD onwards, more than seventy-three thousand every month (Table I Column E).

Around 1660, the preacher John Bunyan wrote in one of his moral fables : "The Captain of all these Men of Death that came against him to take him away, was the Consumption, for it was that that brought him down to the Grave" (19). If efficient, energetic control measures are not taken, year 2001 AD may see the return of "The Captain of all these Men of Death".

Shortfalls on Other Fronts

TB Patient : Mr. Laskar said there were more than 10 million persons suffering from TB in the country and the Government did not have sufficient resources to provide clinical facility to all of them (State Minister for Health, Lok Sabha Questions, Indian Express, 2nd December, 1981).

State's Live-stock : Five per cent of the cattle in the state's live stock farms are infected with tuberculosis and that similar condition prevail in live stock farms across the country (Director of Animal Husbandry. West Bengal). In the case of West Bengal a Calcutta newspaper alleged that

70 per cent of the cattle in state farms died from TB. (Indian Express, 1st October, 1984).

Tuberculosis Leading to Suicide Attempt : On December 13, Mr. Justice Sachar collectively quashed 119 cases of attempted suicide pending in the criminal courts—some of them for years—and directed the Administration and the Police not to prosecute such victims in the future.

There is sound common sense in the judicial decision. For instance, one of the cases narrated by Mr. Justice Sachar had to do with a young man who suffered from an acute case of tuberculosis and was subject to fits and periods of acute depression. The worst thing such a man would need is a year in prison where he might infect other inmates, as well as have a greater reason for attempting suicide once again (The Editorial, The Hindustan Times Weekly, 29th December, 1985).

1000 from PM's Fund for TB Patients : New Delhi, January 30 (UNI) Ram Dulare of Purani Jhushi in Allahabad district has been given Rs. 1000 from the Prime Minister's relief fund for treatment of tuberculosis. The amount was sanctioned on the recommendation of Mr. Ram Pujan Patel Congress(I) member of Parliament from Phulpur of Allahabad (Indian Express, 31st January, 1986).

Dole to Chronic TB Patients : If each chronic TB patient is to be given Rs. 1000/- from Prime Minister's relief fund the total amount required will be Rs. 3.639 million for 1986 and Rs. 5000 million for 2000 AD at the current rates (Table VI).

Economic Factor : *Cost of Treatment* : Approximate cost of treating one TB patient with Conventional Therapy is Rs. 250/- and with Short Course Chemotherapy is Rs. 1050/-. Treatment of one chronic patient costs Rs. 3250/- with a Daily Regimen and Rs. 2500/- with an Intermittent Regimen (Table VII a).

From this one can calculate the cost of treating all new TB patients (Table VII b), which will be Rs. 3635 million with Conventional Therapy and Rs. 15267 million with SCC for 1986. For 2000 AD the cost at current rates is likely to be Rs. 5000 million and Rs. 21000 million respectively.

App. cost of treating failure patients is given in (Table VIII c). The cost comes to Rs. 11797 million and Rs. 9075 million with Daily Regimen and Intermittent Regimen respectively for 1986. Do we have all this money ?

Conclusion

The goal of "Health for all by the year 2000 AD" must be seen particularly in the light of the unsatisfactory health situation prevailing in India at present.

But, surely a nation that can put a satellite into orbit or buy mirage fighter planes, each at a cost of Rs. 25 crores can also get its NTCP to work properly and efficiently.

TABLE—I

Tuberculosis in India : 1961—2001

Column S. No.	A Index	B Rate** %	C 1961 (In million)	D 1981 (In million)	E 2001 (Projected) (In million)
1.	Total Population**		439.23	685.18	1052.50
2.	Prevalence of infectious cases of pulmonary-tuberculosis	0.4%	1.75	2.74	4.21
3.	Prevalence of non-infectious cases of P.I. (X-ray Disease)	1.5%	6.58	10.27	15.78
4.	Prevalence of TB infection but no disease	36%	158.12	246.66	378.90
5.	Annual mortality	4.084%	0.36	0.57	0.88
6.	Annual incidence of new infectious cases	0.13%	0.57	0.89	1.36

**Source* : Health Statistics of India (1984), CBHI DG; of HS, GOI, New Delhi.

***Source* : Assistant Director General of Health Services (TB) Government of India, New Delhi.

TABLE—II

Average Indian District*
(1961 Census)

Total area	10,000 sq. kilometers
Population	1.5 million
Birth rate	41 per thousand
Death rate	18 per thousand
Growth rate	23 per thousand

	Number	Population	% Age of total popula-tion	X-ray positive TB patients	
				Sputum+ve	Sputum−ve
District HQ Town	1	60 000	(4%)	200	700
Taluk Towns	10	20,000×10	(14%)	650	2,600
Villages	1,800	700×1,800	(82%)	4,150	16,000
Total		1,500,000	(100%)	5,000	19,300

**Source* : DTP Manual, The National Tuberculosis Institute, Bangalore, 1974.

TABLE—III

Total Health Facilities Available (as on 1-1-1984)*

1.	(a) Total Hospitals	7181
	(b) Total Hospital Beds (Bed Strength ranging from 1 to over 700)	500628
2.	(a) Dispensaries	21780
	(b) Total Dispensary Beds	35742
3.	(a) Primary Health Centres	7210
	(b) Sub Centres	74307
	Total Health Institutions 1(a) + 2(a) + 3(a) & (b).	110478

Resources Available for Control of TB in India (as on 1.1.1984)**

1.	Institutions rendering anti-TB services	
	(a) District TB Centres	354
	(b) Implemented Rural Health Centres (Estimate numbers)	12390
	(c) Other TB Clinics	330
	(d) TB Demonstration & Training Centres	17
2.	Number of Sanatoria	185
3.	Beds, available	45154
	Total Institutions 1(a+b+c+d)+2	13276

**Source* : Health Statistics of India (1984), DGHS, Government of India New Delhi.

***Source* : Assistant Director General of Health Services (TB), Government of India, New Delhi.

TABLE—IV

Estimation of Overall Level of Success Under NTCP/DTCP

Component	Present Estimats of Level of Efficiencies (%)	No of Successes per 100 cases
Case-finding	30%	30
Case-holding	35%	10.5
Chemotherapy	75%	8
Over all Success	8%	

TABLE—V

Cost of Tuberculosis*

Year	No. of Patients	Cost in Rs.
1966	6.8 Million	20000 Million
1981	13.01 Million	400000 Million**
2001	20.00 Million	? ?

*Dr. K. N. Rao (1966)
DGHS, GOI.
**At the Existing Prices.

TABLE—VI

Dole to Chronic and Failure Patients
(25% of the Total Patients is Lower Estimate)

Year	Total Patients (in Million)	Failure Pts. (in Million)	Dole in Rs. (Million)
1986	14.54	3.63	3630
2001	20.00	5.00	5000

TABLE—VII

(a) App. Cost of Treating one TB Patient

Regimen	Treatment (in Months)	Cost/Patient Rs.
Conventional Therapy		
2SHT/10HT	12	250/-
Short-course Therapy		
2HRZ/7HR	9	1050/-
Treatment of Chronic Patient		
6HRZE/12HRE	18	3250/-
6HRZE/12 $H_2R_2E_2$	18	2500/-

(b) App. Treatment Cost of all New Cases

Year	Total PTS (Million)	Coventional Therapy (Rs. 250/pt) (Million)	Short Course Therapy (Rs. 1050/pt) (Million)
1986	14.54	3635	15267
2001	20.00	5000*	21000*

*At the Exisling Prices.

(c) App. Treatment Cost of Failure Cases
(25% of the Total Patients)

Year	Total PTS. (Million)	Daily Regimen (3240/pt)	Intermittant Regimen (Rs. 2484/pt)
1986	3.63	11797 M*	9075 M*
2001	5.00	16200 M**	12420 M**

*Million.

**At the Existing Prices. □

References

1. Singh, M.M. (1980); Presidential Address, 35th National Conference on Tub. & Chest Diseases, Bombay. p. 2

2. Kamath, R.N. (1985); Information on INABUTOL, Themis Chemical Ltd. Bombay p. 1

3. Rouillon, A. (1982); Bull. Int. Un. Ag. 57, p. 200.

4. Barua, B.N.M. (1977); Tuberculosis in India, CHEB, DGHS, New Delhi. p. 16.

5. District Tuberculosis Programme Manual 1974); National Tuberculosis Institute, Bangalore. p. 1,5.

6. Piot, M. (1962); Proceedings of the 18th Tuberculosis and Chest Diseases Workers' Conference, Bangalore. p. 143.

7. WHO (1960); Tech. Rep. Ser. 195.

8. Text-book of Tuberculosis (1981) Vikas Publishing House Pvt. Ltd. New Delhi. p. 47, 48.

9. Rao, K.N. (1966); Ind. J. Tub. XIII, p. 87, 88.

10. Piot, M. (1962); Ind. J. Tub. 1X, p. 151.

11. Banerjee, D. (1981); Textbook of Tuberculosis, p. 530.

12. Symposium on NTCP (1974); Ind. J. Tub. XXI, p. 112.

13. Health Statistics of India (1982); DGHS, Govt. of India, p. 59.

14. Radhakrishan, S. (1983); Ind. J. Tub. XXX, p. 3.

15. Sivaraman, S. (1982); Ind. J. Tub. XXX, p. 82.

16. Mathur, G.P. (1982): Personal Communication, New Delhi Tuberculosis Centre, New Delhi.

17. Kohli, M. (1983); Thesis for the Degree of Doctor of Medicine (Paediatrics), Uni. of Delhi, p. 33, 36.

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Child Care—National Health Policy

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Children of today will be the adults of tomorrow. Any efforts today for improvement of not only early child health but also child life in general will thus be considered as investment for future. Childhood is the breeding time for the future leaders of the country in different walks of life viz. Industry. Education, Social Services, Politics, Administration, Military and Civil Services. Any investment on services for the young generation has a direct impact on long term economic and social development. Health is an inter-related subject and this involves many other disciplines. The declaration of ALMA ATA by WHO is considered to be the MAGNA CARTA of health development. This understood the role of Primary Health Care as the key to the attainment of the goal.

India is a signatory to achieve Health for all. The National Health Policy had been approved by both houses of parliament signifying the political will for the implementation of the policy.

The targets set to be achieved reveal the vital role of Maternal and Child Health in Health Services.

The Existing Picture of Child Health

The child health problems of India and other developing countries are similar to the problems seen in 19th Century Europe and U.S.A. In the West. dramatic changes have taken place in child health as a result of early and continued efforts of Paediatricians combined with those of immunologists, pioneers in public health and nutritionists resulting in very marked reduction in childhood mortality and morbidity. In India with successive 5 year plans, a significant improvement in the health status of the people have been achieved, like eradication of small pox and plague and prevention of many other epidemic diseases. Inspite of these various mentionable achievements health care services particularly child health services continue to suffer from several deficiencies. There are serious locational and quantitative imbalances in services provided to various sections of the population.

The number of deaths in infants and among the children under the age of five is the most commonly used indicator of child health status within any country and a good gauge of the country's stage of social development. The risk of dying before adolescence is about 1 in 40 in the developed world. In India it is 1 in 3 or 4; 50% of total deaths occur in children below five years. Further study of mortality reveals that about 1/3rd of all deaths occur in the first year of life, nearly a fifth of all deaths occur in the first month and about 1/10th of all deaths occur in the first week of life. For every fatal outcome there are many episodes of disease and ill health.

Beneath this trend is a complex of attendant factors like maternal malnutrition, foetal under development, inadequate natal care, improper infant feeding and weaning practices, malnutrition like vitamin 'A' deficiency, Iron deficiency, Protein—energy deficiency, preventable conditions like diarrhoeal dehydration, infections like tetanus, whooping cough, measles and ignorance about growth failure. The health problems are ingrained with poverty, ignorance and inertia of life style of the community that, in order to make any change for the better, it should involve a change in life styles, feeding and living habits of the community. The profile of child health problems should form the "SHEET ANCHOR" of health services strategy including a health manpower development policy.

Objectives and Imaginative Approach to Child Care

The fundamental concept in child care must be intrinsically different from adult care. The problems and solutions in providing health care for village people are intrinsically different from traditional medical practice. The unthinking tendency to transpose primary care as practised in hospital, out-patient department or physician's private office to rural centres has not met the need of the community. How best can we defend and protect human life as soon as it begins in the human womb upto the time it reaches addescence ? Every child born in our country must have the opportunity to realise in full his capacity for material, intellectual and spiritual growth. The techniques involved in reducing the problem of children have not been fully worked out. A mention in the constitution a plank of policy and a place in planning is not sufficient. Development of the very young ought to be the paramount national concern. The health policy has to define the most appropriate pattern of services for children.

Status of Child Health Care in National Health Policy

The national health policy specifies clearly the goals to be reached for health and family welfare programmes. Improvement in vital health indicators like perinatal mortality, infant mortality, preschool mortality has been stressed establishing accountability. The policy lays stress on the preventive, promotive, public health and rehabilitative aspects of health care and establishment of Primary Health Care Services to reach the population in the remotest areas of the country. Ensuring adequate nutrition, safe drinking water supply and improved sanitation for all segments of the population and health education are the other high lights of the policy document. The seventh five years plan is largely guided by the national health policy. The importance of delivery of Maternal Child Health Services had been emphasised in the policy and plan. Improving child health has been deliberated in several committees. The translation and application of recommendations are far from satisfactory. In planning for implementation of a new pattern of health care it is necessary to recognise the inter relatedness of a number of interlocked components. If any of these elements are missing than the whole system may not work.

Programme that are likely to have maximal impact in childhood mortality and morbidity have been spelt out—The achievements in child health care are meagre as drops in the ocean. While the 7th plan has been explicit in spelling out targets, it has not provided details of strategies or programmes by which these targets would be achieved. In this communication, policy and programmes will be reviewed and suggest where actions and alterations are required.

Medical Education

The medical education system and health care delivery system have each gone their own separate ways. The greatest need is a system of education oriented towards the promotion of community health and primary health care. The pivotal place that child health should occupy in any health plan is so blindingly obvious that most decision makers in health planning have failed to see it. The recommendation on undergraduate paediatric education of the Medical Education Conference convened jointly by the Government of India and Rockfellor Foundation in 1955 were accepted by Medical Council of India (MCI) only in 1966. Medical Council of India recommended undergraduate assessment of this discipline only in the year 1976.

20 years after Medical Council of India's recommendations, majority of country's Medical Colleges are not providing the required 3½ months undergraduate Paediatric Training. Paediatrics is assessed independently only in three Universities of this country. Majority of Universities are not assessing undergraduates in Paediatrics at the final professional level, contrary to the 1976 recommendations of the Medical Council of India. The discipline of Paediatrics has been neglected inspite of political will, support of International Agencies like WHO and UNICEF and commendable efforts of Paediatric Educationists. The inadequate knowledge of Paediatrics possessed by a great majority of those in private practice, doctors in non-teaching hospitals and Primary Health Centres is mainly due to defective undergraduate training. Offering good and comprehensive Paediatric Services to India's large child population will depend mainly on the quality of undergraduate training in Paediatrics. There is an urgent need for total implementation of Medical Council of India recommendations on undergraduate paediatrics education and to make it a totally independent discipline at the undergraduate level.

Continuing Medical Education—An Urgent Need

The character and nature of medical practices have radically changed in the last few decades and is constantly changing. A major objective of medical education today must be to train the student to continue to be a student and to equip him to imbibe and effectively utilize relevant new knowledge. The teacher must keep continuously abreast of the fast moving frontiers of knowledge in this field. In the last few years a child survival and development revolution has begun with low cost inventions like oral rehydration therapy, universal immunisation growth monitoring breast feeding, proper weaning and food supplementation, female literacy and family spacing. How many physicians in practice are aware of these advances ? It is a great challenge to disseminate latest knowledge without delay and which is rapidly changing to each and every practising physician.

There is not even sufficient awareness of the enormity of these new challenges.

A pattern of undergraduate and continuing Medical Education has to be evolved in the country which will adequately meet the new needs generated by the rapid advances in Medical Sciences. Just as in some countries like U.S.A. Programmes of re-training and re-licensing after assessment for physicians to practice has to be seriously considered and introduced without delay. The present trend of Medical Education being —once for all phenomenon—must be changed. Medical faculties can make a valuable contribution to the development of Primary Health Care by providing instruction for field workers and monitoring progress.

Nursing Education and its Relevance to Child Care

The term Nursing Personnel includes all persons who carry out nursing functions like general nurses, public health nurses, nursing tutors, auxillary nurse and midwife and others. The curriculum content prescribed by Indian Nursing Council is accepted by all nursing schools and is unsatisfactory and very inadequate in Paediatric Training. The development of Nursing Profession is no less important to the care of children than the development of medical profession. Nurses have a major part in improving health of the children and have the greatest potential to expand further and raise the standard of health. There is an universal problem of shortage of nursing faculty. Starting of private nursing schools are in greater need than medical schools. Continuing Education Course in Paediatric Care and community health care is essential for professional growth and to enhance job performance. Nurses profession has to be accorded its rightful status and recognised for the valuable role it can play in achieving the marked reduction of childhood mortality and morbidity. In the light of forgoing discussion the training of pharmacists and other paramedicals also needs change.

Drugs and Pharmaceuticals in Child Care

The drug policy speaks mainly of self-reliance and abundance of drugs to meet our health needs and do not lay emphasis on the pattern of drug production. It is more important to see what drugs are produced and for whom ? There is, however, production of costly drugs for the rich and cheaper drugs required by the poor people are not adequately available. (e.g.) Phenobarbitone, Dapsone and INH. There is also vaccines shortage. Irrational marketing of drugs and continuous availability of some spurious harmful and dangerous drugs are hazardous. The pattern of drug production of the country should be closely oriented to the disease pattern and details have to be spelt. Urgent steps are needed to improve the efficiency of public sector. The need for an effective quality control machinery does not require any emphasis. It is necessary to amend the drug policy suitably.

Care of Children Above Six Years

The children above this age group form nearly 20% of the population. There is a vagueness and lack of clarity about the welfare both in plan and policy. All programmes are limited to the school health services.

Many more children in this age group are out of school than in the schools. It is therefore important to realise the special problems of these children. Promoting uninterrupted growth and development in them an important aspect of human resources development. Growth retardation in girls aged 10-15 years lead to low pregravid weight and short stature leading to obstetric complications and cause low birth weight. It is therefore important that their needs on health care be stressed in national health plan and separate provisions are to be made for it.

Health Insurance and Mobilisation of Resources to Improve Child Health

The primary responsibility of providing health services to the people is that of the Government. It is extremely doubtful that the present patterns of resource allocations can establish a minimum health organisation considered absolutely essential to meet the basic health needs of the community. If the community share some of the cost, it will maximise the efforts. The availability of free medicine should be restricted only to National Health Programmes, e.g., Leprosy and to the vulnerable population. This will improve community participation in health activity and facilitate reattendance. Charging nominal rates for investigations to out patient and indoor patients and diet is practicable. It is essential that a definite and a discrete order is issued without delay.

Intersectoral Co-ordination and Child Care

Attainment of nationwide goals, specially social objectives is possible only through sustained national will and co-ordinated efforts by all related sectors. Health development is both a cause as well as a result of social and economic development. Efforts at achieving co-ordination and establishing linkage have to cover Integrated Rural development, education, social welfare, agriculture, industry, transport, etc. to ensure protected water supply, environmental sanitation and hygiene, nutrition, MCH., and Family Welfare. A highly co-ordinated and integrated approach involving all sectors is possible only by sustained political will and support given both at centres and states throughout.

Conclusion

The country is preparing to enter the next century with hopes of a prosperous nation using up dated technological advances and developments in different fields. If these hopes are to be realised child health needs top priority, as children are country's most potential resources. The problem of reducing childhood morbidity and mortality is complex. An effective sustained decline can only be achieved by a multipronged approach aimed at social, ecological, educational, public health and environmental problems. If a dent is to be made on maternal and childhood mortality the Government should without delay and reservations implement the recommendations as these are highly specific and need based. □

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Teaching of Human and Moral Values in Postgraduate Medical Education

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A postgraduate medical student after completing his training is likely to work as a clinician, a medical teacher, a medical administrator and/or a medical researcher. During his professional career, he is likely to face many situations where he will have to take decisions not only on scientific basis but also on human and moral principles. His acts should reflect upon his character as a man of virtue and not as an a moral being. Intentionally or unintentionally he may speak ill of a professional colleague, be unkind to an anxious patient suffering from advanced cancer, recommend purchases from a particular firm which gives his gifts, select a student belonging to his region, award low marks to a student whom he does not like or steal ideas for research from a junior colleague. Although the present system of medical education imparts good theoretical and practical knowledge on scientific medicine, there is no formal and very little informal education on human and moral values during post-graduate medical training. Emphasis is being placed on learning operative acumen e.g. how to do prostatectomy but little importance is given to humanistic treatment of a poor old patient or the moral aspects involved in decision making of various real-life situations such as patient management, medical education (student selection, examination, etc.) medical administration and medical research.

The moral components are :

(i) *Attitude* : It is not simply an ability or a piece of knowledge. It is "regarding other people as equals", "thinking that other people's interest count", "taking notice of other people's wants and needs". Attitudes are detected and verified by the way in which a person thinks in his everyday, practical living, and to some extent by the way in which he acts. On the cognitive side, it is a belief—the belief that other people have equal rights with onself. This can be tested by certain question or observations :

- (a) Does he make some effort to find out what other people's wants and feelings actually are ?
- (b) Does he listen to other's opinions and allow them to have their say ?
- (c) How does he actually treat people belonging to a different ethnic origin/different region/different religion ?

(ii) Ability to know what other people are feeling, in particular situations. This may be described further as "awareness of other people's feelings", or "the ability to understand what other people's interest are", "knowledge of other's desires, emotions, etc.". This is concerned with awareness of the feelings of people with whom one actually comes into contact in one's everyday life! it also includes being able to predict the feelings of those whom he has never met. This can be tested as follows :

  (a) Can the student give a reasonally good account of the feelings of the patient who is to undergo extirpative surgery e.g. total amputation of penis for penile carcinoma?

  (b) Can he understand the feelings of the patient's wife and children when a diagnosis of advanced cancer of urinary bladder is made?

  (c) Is he interested in other people's feelings and behaviour? Has he as a teacher, made any attempt to understand the feelings of his students? Has he as an administrator made any attempt to understand the feelings of his subordinates?

(iii) Actual knowledge of certain 'hard' facts—Knowledge of rules of the social system in general, knowledge of social conventions and social expectations.

(iv) Know-how to translate his moral decision into effective action. It is a kind of adeptness rather than a cognitive mastery of facts. This can be tested by :

  (a) Is he capable of playing the roles of a leader and a follower, of issuing and obeying instructions?

  (b) Can he behave efficiently in social situations involving people of various age groups, and different ethnic origins?

  (c) Can he behave well in formal contexts as well as in less formal contexts?

(v) *Mode of thought*: Ability to face up to a moral situation and to consider that situation primarily in terms of other people's interests. A person with appropriate attitude, ability to discern other people's feelings, and knowledge of 'hard' facts will make a prescriptive moral decision dictated by other people's interests. Dimensions of this complex moral component are (a) right reasons. Not everybody makes, or even thinks he ought to make, his moral decision on the basis of other people's interests. Other modes of thought are regrettably common. Amongst these are: desire to please the boss, uncritical tendency to obey rules, a tendency to do what is most expedient for oneself, etc. The person with a high degree of this moral component will always consider other people's interests, and think in this mode rather than in others. (b) Sincerity of decision. There are people who may pay lip-service to a certain mode of moral thinking but who do not sincerely *commit* themselves in making these judgements. This can be tested by the following questions :

(a) Does he think that moral values are 'just a matter of taste' or does he believe that there are right and wrong answers to moral questions?
(b) Do his principles include not only avoiding bad actions, but doing good ones (actively and positively helping other).

(vi) *Action or Behaviour*: When a person has reached a rational moral decision, he must have the motivation and resolution to translate that decision into action. There are all sorts of reasons why people fail to bring their abilities to bear on moral situations, or fail to translate their moral decisions into action. They may be forgetful, incompetent, lazy, frightened, tired cowardly, etc. A person should have sufficient sentiment or love for other people: this is atleast one kind of motivation which should enable him both to think and act rationally in the moral sphere. A person should also have good habits, or a settled disposition to think and act in a rational manner. A person must possess independence of judgement, the ability to think and act autonomously as opposed simply to following other people like sheep. A person must be reflective or thoughtful enough not to be carried away by particular situations, and not to be forgetful of other people.

Teaching of moral and human values

The spirit of the medical college and its teachers thus becomes the basic factor in developing moral values. There can be little contribution to moral and spiritual values from a college which resorts too easily to arbitrary authority; from an institution in which the chief mainspring of effort is rivalry; from an institution which fails to exhibit complete honesty; from a college in which each seeks only to satisfy his own selfish aims; from a college laden with intolerance, fear and suspicion. Only a medical college served by a faculty whose members are themselves sensitive and responsive to moral values; a college with a broad, humane, and flexible curriculum; a college steeped in a philosophy which commands respect for the personality of each teacher can hope for success. Medical colleges that exemplify moral values are better than lesson which preach them.

Human and moral values can be taught while discussing each patient's clinical problem. The teacher should be a 'role-model' in exhibiting human values while treating a patient. He should observe the students in the out-patient clinics, in the wards, and in the operation theatre, record resident-patient encounter and discuss it with the concerned resident later emphasising the need to adopt and practise humanistic approach and moral values. For example, the urology resident is often taught how to do urethral dilatation i.e. he should fellow aseptic principles, there should be no urethral bleeding, etc. Seldom is it emphasised that he should alleviate the anxiety of the patient before performing dilation, make an attempt to understand the feelings of the patient's family as regards patient's illness, check whether adequate urethral mucosal anesthesia has been produced before actually performing dilation. Not infrequently it may be witnesses that the doctor scolds the patient when he complains of pain. Thus the human values should be integrated with the teaching and practice of clinical medicine. Often it may be observed that the teacher as well as the post-graduate student is kind to a VIP patient but forgets such human values while attending to a poor and illiterate patient.

The moral components mentioned above can be taught in the medical college during case discussion, structured lectures, informal coffee-club discussions, departmental seminars, interdisciplinary seminars and intensive workshops. At a national level, bibliography development, national workshops and national conferences on teaching of human and moral values can be organised.

Evaluation

Assessment of teaching of moral values, student's learning and student's behaviour in this regard should be periodically evaluated. Preferably, considerable weightage should be given to the above listed moral components in internal assessment of non-scholastic abilities. Self—assessment by the post-graduate students is the best method of evaluation to infuse motivation and self-analysis. He may be encouraged to record atleast one patient management every fortnight describing how he adopted human and moral principles. The teachers should act as facilitators of learning and directors of individually-prescribed instructional programmes. They should give immediate, positive feed-back to the student appreciating his good performance and encouraging him to make up his shortcoming if any. Peer assessment, and evaluation of recorded audiotapes of resident-patient encounter may also be useful. In the beginning, all groups may express some antagonism or unwillingness to admit to living by moral values. However, the teachers as role models, will be able to secure student's full participation in such programs. When the students are encouraged to think harder about these abstract ideas and given a little help with the terminology, they would quickly become adapt at analysing the moral issues involved in patient care, and in his professional career.

In conclusion, moral education involves both comprehension and apprehension, neither can be imposed. It is wholly open-ended, recognising that genuine morality requires free personal acceptance of values of that is, the goal is not the heteronomy of the slave, but the autonomy of the free man. ☐

References

1. Bull, N.J. Moral Education London, Routeledge and Kegan Paul, 1973.

2. Educational policies Commission. Moral and spiritual values in the public schools. National Educational Associations, Washington, 1951.

3. Jewell, M.D. Teaching Medical Ethics. Br Med. J. 289: 364-365, 1984.

4. Veatch, R.M. and Gaylin, W. Teaching Medical Ethics: An Experimental Program. J. Med. Educ. 47: 779-785, 1972.

5. Wilson, J. Moral Education and the curriculum Pergamon Press London, 1969.

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Artificial Insemination-Surrogate Parenthood Ethical, Moral, Legal Aspects

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Human mind is conditioned by a large number of factors. What is legal or illegal, what is ethical or unethical, what is good or bad, what is moral or immoral, what is sinful or otherwise are all determined by an individuals upbringing, his immediate social and cultural environment, his religious background and a host of such other factors. All of us tend to develop, what in transactional analysis are called "Scripts" resulting from Parent-Adult-Child interactions, within ourselves, and with the surroundings. Rapid scientific advances which are both as a result of and which result in information explosion are producing a positive feedback effect. We do not know where this accelerating cycle will lead us to. Any organism, organisation or system needs a strong and sensitive negative feedback component to maintain it in a state of homeostasis or equilibrium. Even if it is a forward moving accelerating system, it requires inbuilt mechanisms to check its progress and to absorb the shocks. It is also essential that all parts of the system move at the same speed, to maintain the integrity of this system. Most individuals are quick to accept newer techniques if they lead to monetory gains to them. Even an illiterate farmer in India readily accepts hybrid seeds, chemical fertilisers, pesticides, and newer methods of farming if he is convinced that he will get bigger financial returns. In fact at the back of his mind he has been looking for such inputs. Such inputs have in fact come up as a result of such a need. Most of us will also accept, though a little less readily, newer options in the field of health. In my field of rural health programme I find that the rural farmer accepts much more readily newer techniques which look after his animals than those which improve the health of his children. If the social system is slow in accepting newer health techniques, the legal system is still slower in accepting the facts if life as it were. If the legal system is slow, religious system is practically static. What may be acceptable socially and legally may still be considered intolerable from a religious point of view.

A.I.D. and surrogate parenting are problems, where medical science has advanced very rapidly. To-day it is possible for a woman to conceive without any sexual relationship with a man. The sperm could come from her husband or from any other man who may be miles away from her, or may be dead since long. It is now possible to collect the ovum (egg) from a woman, get it fertilised outside in vitro, get it embedded in the uterus of some,other woman. Time is not far when it will be possible to produce an entire new individual by cloning from a single cell of any one of us. A sexual reproduction from a single cell was the earliest form of reproduction. With cloning the cycle will be complete.

Law in most countries has not yet taken cognizance of all these developments. An AID child is still illegitimate in many civilised countries of the world. As is found in most instances those who want to do things legitimately face problems. One of the report states that in 30% of couples it is found on detailed examination that the father could not be the genetic father of the child in the family. Women seem to be finding their own means of attaining pregnancy. It has been rightly said that the results of AID can also be obtained by adultry. Seeing newspaper reports about surrogate parenting, physicians are approached by aspiring couples to help them out of their predicament. In India and also in many other countries, producing at least one or two children is not only an instinctual necessity or a socio-economic need but also a status symbol. A married couple is under great social pressure to conceive soon after marriage. A sterile woman is not only looked down upon but is considered inauspicious. This makes it obligatory to conceive by hook or by crook. Any scientific advance in the field of human reproduction is therefore not only appreciated but also demanded by the community. Such advances are eagerly looked forward to, and heartily welcomed by those in need.

Oxford dictionary defines Surrogate as "Substitute" or "deputy". The phrase surrogate parent would therefore mean a substitute parent. Surrogate father would be one who substitutes for the father or deputised to be the father. 12% of all married couples are faced with the problem of sterility. While some of them can be helped by simple means, most of them would have problems, where at least one of the partners is not in a position to produce the required gamete (sperm or ovum). In such cases it would be essential to obtain the gamete from a third party. In case of such a problem with the male partner, the biotechnical part is restricted to obtaining the gamete from a suitable fertile male and introducing it it into the fertile female. In case of inability of the female partner to produce the ovum, it is possible to obtain it from another female, and after fertilisation in vitro with the male partners sperm, implant it into the uterus of the female partner, after suitable preparation. In those cases where the female partner is not in a position to embed a fertilised ovum (either her own or of another female) it is possible to embed the ovum in the uterus of a suitable female for its growth and development. All of the above alternatives are not only possible but are likely to be generally available shortly.

In case both the partners are not producing gametes, inspite of medical interventions and where other alternatives also do not yield any results adoption is the only alternative. The parents of the adopted child would be substitute parents for that child. Adoption has been practiced since long. It is a well established custom. There are no ethical or moral issues, except when a child is sold for adoption or is purchased with an idea of subsequently using it for immoral or commercial purposes or for labour. Legal procedures for adoption are well established, but like all legal matters there will always be some loop holes lacunae. Interpretation of legal phraseology may also sometimes lead to some problems, but by and large the issue can be said to be as settled as any other legal matter. Other matters like AID, IVE, ET and hire-a-womb are matters with which law has not been able to keep pace with generally.

There are five or six characters in this drama.

1. *The doctor*: The medical man or the medical team would be well advised to take the following precautions.

(a) Take valid written consent of husband, wife and donor, for the procedures.

(b) Try to keep the identity of the donor a well guarded secret.

(c) Carefully select the donor to closely match the partner he or she is to substitute with the same blood group and without any bad genetic traits or transmissible diseases.

(d) If possible get a psychologists opinion about the couple's mental stability to accept the off-spring.

2. *The father*: He should be fully explained the procedure and be asked to remain present during AID, if possible. It is also possible to mix the semen of an oligospermic husband with that of the donor in order to give a chance to his sperm to fertilise the ovum. This combination procedure is known as AIC and can also be tried in suitable cases. For birth registration father's name should be left blank.

3. *The mother*: In case of AID the mother is very keen to be pregnant. So also in case of IVF and ET from another woman. There should be an unwritten pact that this matter will not be brought up during any domestic quarrels.

4. *The child*: In some countries or in some states of some countries such a child would be considered illegitimate. It is better to legally adopt the child as early as is legally possible. From medical point of view it is better if the child is informed, when it grows up, about its origin so that there is no confusion in medical history about genetic disorders.

5. *The donor*: He or she should give accurate and correct history about illnesses suffered and family history. They should not make attempts to find the outcome of their donation.

6. *Uterine mother*: In case of uterine mother it is better to find one who does not do this for money. It is better if she has two or three children—boys and girls, so she is not tempted to keep the child. Pregnancy even under best of circumstances can sometimes lead to mortality or morbidity. She should be explained about this. She should be fully instructed against consumption of alcohol, smoking and taking drugs which may be harmful to the foetus. The period for which she will be required to nurse the baby should be explained.

AID is already available as a eugenic measure. There is an attempt to produce a race of supermen by using sperms of intellectual giants. There is also demand from unmarried women to get pregnant through AID. Once it is possible to do IVF the day is not far when it would be possible

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AID: Artificial Insemination by Donor semen
IVF: In Vitro Fertilisation
ET : Embryo Transfer

to alter the genes prior to fertilisation by genetic engineering. Once a desired type of individual is produced he/she can be replicated by cloning. Though sexual reproduction by normal sexual intercourse is unlikely to lose its popularity for a long time for obvious reasons, some day in future it will be possible to totally separate the procreational and recreational aspects of sex. Whether this will be of benefit to mankind or not time alone will tell. Science keeps on producing deadliest weapons of destruction and also newer means of production and reproduction. At a micro level they can be of use but at a macro level their usefulness is questionable. Science, morals, ethic, religion and good sense will have to by synthesised, if a Frankenstein is not to let loose. ☐

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Health for all by 2000 A.D.— Measures to Implement

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The World Health Organisation and the Government of India are keen on providing "Health for all by 2000 AD" utilizing all the available resources, manpower and funds.

At present all the efforts of the Government is mediated through Government agencies only. Only a very few non-Governmental agencies and voluntary bodies take active part in the implementation of Government Health Policies.

The primary defect in this system is the dilution factor. The idea and the motivation with which the existing policies were framed, get diluted as it percolates through the hierarchy of administrative machinery and practically very little reaches the common public who are at the receiving end. In addition number of social and political evils contribute all their might to dilute this further.

It is a known fact that three fourth of our trained medical people live in urban areas and three fourth of the Indian population live in rural areas. Thirty eight years after independence, we are not able to provide safe drinking water to all our people and how are we going to solve the problem of providing health for all by 2000 AD ?

A radical change in the approach is required and the mere fact that our health policy has not benefitted the masses indicate the necessity of taking on war footing in solving this problem.

Implementation of Governmental Health policies is a slow process and the Government employees deal only with papers, rules and regulations which involve least quantities of logic and rationals. Motivated local voluntary agencies can solve a lot of these drawbacks, of the administrative machinery, *provided REAL conscientious supervision over the activities of these organisations can be established.*

This point has been well brought out in the speech delivered by Dr. Sathianathan at the 1985 National Workshop of Health Services Research in which he said "one of the remarkable features of Private practice is that even though Government facilities are chronically short of drugs and other supplies in most of the places, the private sector invariably manages to purvey basic medicaments even in remote areas". It is a common knowledge that if a particular drug is not available in the Government Hospital the nearby pharmacy will definetly have plenty of stock of that particular drug.

The main aim and the objective of this paper is not to criticize the working of the Governmental Institutions but to evaluate a method by which the health of the Indian population can be substantially improved by 2000 AD.

The main impediment towards this is the lack of *DATA*. We actually do not know what we lack or suffer from. Only when we know the deficiency, it can be corrected. Hence the major proposal of this paper is to emphasise the baseline data collection from the entire population of this subcontinent in the next 5—10 years. Only when the basic health records of the population is available for analysis we will know what we lack and suitable remedial measures can be initiated.

How to Collect Health Data

Collection of general health data and socio economic status can be entrusted to Government field workers, health visitors and local voluntary agencies and educational institutions.

For example in Tamil Nadu all the Taluk headquarters has atleast one college of higher education where students from the neighbouring village come for learning. If these students are motivated and made to understand the importance of this health data, reliable data can be collected from the students native village.

Regarding the common illness disease and nutritional deficiencies in a particular region, the necessary data can be collected by the medical practitioners working in these regions who are again to be educated to understand the significance and necessity of such data. As pointed out by Dr. Sehgal (1985) the importance of Record keeping should be emphasised for Rural doctors and when these records are kept properly are valuable tools in obtaining disease statistics in a region.

On similar lines private laboratories and hospitals IMA, and the voluntary agencies receiving Government grants should also be involved in this data collecting work.

Keeping records on health problems of people can easily be solved if Government introduces health cards similar to ration cards. These health card system is already in vogue in number of Western countries and it is high time Government of India takes some steps towards initiating the card system.

Similar health card systems are in use certain voluntary agencies like V.H.S. Madras, and with many of the urban private practitioners. Some of the special departments of Government hospitals maintain their own card system. But what is needed is such a practice should be adopted by all the medical people and institutions so that data collection becomes relatively easy.

No doubt these data collection, storage and retrieval needs considerable investment in time and money. Proper motivation of the people and physicians and incentive for both the group may atleast solve the problem to certain extent. In larger institutions computerisation may be essential to store and retrieve data and the money invested in this is definitely not a waste.

The functioning of this data collection network is ultimately depends upon how efficiently the working is supervised and managed; again dedicated supervisory and supporting staff are essential.

Role of Doctors in Data Collection

Once upon a time the medical profession and the medical men and women were available for service at all time. This continues even today in remote rural areas but most of the medical professionals in Urban and suburban regions are far from service oriented. Motivating these people in this mass data collection process is rather difficult. Reorientation courses along with refresher courses to motivate the medical people in participating the mass data collection is essential. The local medical association can do a lot in this respect and these bodies should be encouraged and a scheme should be organized regionwise so that all the necessary data will be collected by medical professionals. An incentive scheme may also be introduced to encourage the medical personnel to actively participate in this programme.

Role of Hospitals in Data Collection

Though it is a routine practice now to maintain the case records by the record section in major hospitals the input seems to be defective. The information fed to the Record section is spurious at many instances. It has come to the notice of the authors some time back, that cases diagnosed as Rabies have been cured and discharged as per the records. Education regarding the necessity for sincerity should be emphasized to avoid misrepresentation of data.

> Similarly the most of the records never show the real cause of death in hospital patients, because regular postmortem is not the rule for hospital patients.
>
> Postmortem should be made compulsory in all the hospital deaths and proper postmortem records should be maintained along with suitable specimens for future analysis in cases where the diagnosis is doubtful.
>
> Very few hospitals conduct regular mortality case discussion

which should be made compulsory where in all the concerned medical personnel should participate. Mortality due to negligence can be minimized by this techniqe.

Similarly local clinical and Research society meetings must be made compulsory for all the hospital medical personnel.

Data Through Drug Stores

Data collection through Drug stores and pharmacies can also help in assessing the health status of the local population. Hence the pharmacists should also be educated in the significance of record keeping. To cite an example if the consumption of antihypertensive drug is more in a particular region the cause must be investigated in depth and such a study may show some interesting data on the etiology of hypertension.

Stringent drug rules and their strict enforcement will save thousands of people from the malady of spurious drugs and promote positive health.

Role of Statistician and Computer

These base line health data and the illness data collected by various sources should be meaningfully analysed by competent, dedicated experts in statistics to be of any future use. Since India is a vast country, the quantum of data collected will be astronomical and it is impossible to analyze them without the help of computers, i.e. suggested to have minor computer centres at district level linked to a major computer centre at state level which in its turn is linked to the master computer at National level. Data fed into any of the peripheral should reach the Master computer unit in a day to be really useful. The result of these statistical analysis should be fed back to the concerned people who are responsible for collection of data to show various correlations and inference obtained in a simple non-technical manner, which will stimulate the morale of these tail enders and others to collect more reliable data enthusiastically. Cross checks should also be made to minimize the entry of wrong or spurious data and severe deterents should be instituted to those who feed false data.

Some Special Aspects to be Considered

Special attention and care should be given to the health of children and when education becomes compulsory, health education in schools will go a long way in improving the health of the nation. Though health education is available in schools of Urban area, schools themselves are non existant in many of the Rural areas. Further health education to girls should be given special emphasis since a previous study in Kerala has shown that educated mothers have smaller families than uneducated mothers. Similarly a health educated mother will propagate the value of health to her future generations better than the males.

Since India is rapidly progressing in Industrialization proper health care should be given to industrial workers and their family to protect them from known occupational hazards. Pollution from industries should also be borne in mind and the rules enforced strictly will go a long way in health of people of industrial belts.

Practically no official data is available on alcoholism and drug addiction in India. Since prohibition has been lifted in most of the states in India, and drug peddling has also come to the surface, data on these areas are absolutely necessary for proper planning the course of future action.

Lack of data or its availability and lack of proper analysis of data has lead to the failure to understand the magnitude of certain conditions like :

(a) Incidence of Leptospirosis and Malaria in India.

(b) Incidence of Silicosis in quarry workers.

(c) Correlation between nutritional status and prevalance of diseases.

Finally the authors personally feel that it is the high time to reorient the entire medical and para medical education towards positive health approach if we are really serious about Health for all by 2000 AD. Nutrition and social and preventive medicine should be the major components of Undergraduate as well as Post-graduate medical education which are being given step motherly treatment in our present curriculum.

Based on the data collected and analysed, proper planning should be initiated in consultation with local bodies to eradicate diseases and to promote positive health. ☐

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The story of Child Health in India is one of needless, avoidable disabilities, and missed opportunities. Child Health is not an individual problem. It is a family and community problem and has to be tackled at the community basis. 70% of India's children live in rural areas. The health needs of the children in our country are entirely different from those of affluent countries and do not require sophisticated technology. There is a need to ensure that resources whatever their origin are channeled in to socially relevant health action-Multisectorial Mass Action for social change. A comprehensive National Health Policy has been accepted by the Parliament signifying the political and Government will to Achieve Health For All by 2000 A.D. The targets to be achieved stresses the importance of Maternal and Child Health Services. The policy emphasises the preventive, promotive and Public Health and rehabilitation aspects of health care and establishment of Primary Health Services, to reach the population in the remotest areas of the country. Ensuring adequate Nutrition, safe drinking water supply and improved sanitation for all segments of the population and Health Education are the other highlights of the Policy Document.

Like any other field of science, Medicine is witnessing a knowledge explosion in all aspects. Advances in Paediatrics started as a trickle in fifties, became a rivulet in sixties, a torrent in the seventies and a flood in the current decade. There is a wide gap between available knowledge and its availability to the most needy. Obviously we need a break through not only in science and technology but also in organization, management, education and motivation. It is in the application of what we know that we are failing even more than in the discovery of new knowledge. It is a tremendous challenge for all of us if we wish to meet the Rural Children's Cause and Commitment.

The nation has developed a plan for rural services to meet the needs of Mother and Child Health Care and Family Welfare. The assessment of available resources, their proper allocation, efficient utilization are important considerations for providing efficient Health Care Delivery. Primary Health Care envisages a community based health system which will emphasise the interdependence of health and development in all ramifications and ensure the equitable distribution of available health resources leading to accessibility and efficient health care. So optimum mix of personnel of health and non-health sectors has to be done for most efficient health care services.

In India since our Independence, with the establishment of Primary Health Centres and Rural Community Development Programme, it was possible to take modern health development of people living in farflung and hitherto inaccessible areas. Still the improvement in Health and Nutrition Status of children is not commensurate with the effort. This has brought in to question, review of the entire activity of Health Care Delivery with a view to evolve a strategy more suited to the country's condition. Health is not medicine alone. Health development cannot be restricted to the development of medical technology alone or devising, ways of applying the technology. Primary Health Care has to look beyond health sector. It is time to veer away from the concept of Medical Personnel working in isolation.

The members to constitute the rural health development team and their job responsibilities have to be redefined. There should be a vigorous effort to integrate all agencies like rural development, agriculture, Womens' Welfare Education, Nonformal Education and voluntary associations and departments involved in the challenging task of improving the quality of children everywhere. There is a need for a fundamental change in the organisational set up in the block level. In the present changing situation the Health Development Team has to co-ordinate various activities to maximise efforts and accelerate development.

Team is defined as a group of people working together towards a common goal. Team work is pooling of efforts co-operative working for a common cause. All group of workers concerned with health development, promotion, maintenance and recovery of health and prevention of diseases-are members of 'Health Development Team'. These members have different qualifications, grades, strength, experience with different types of responsibilities varying according to the tasks it has to perform. The challenge of achieving uniform health development is greatest in the villages. All sectoral plans and programmes for the social development in the villages have isolated approaches quite independent of each other with obvious overlap. It is imperative that if we are serious to achieve meaningful results within the next decade, within the financial resources, there is no alternative to the exploitation of available manpower and financial resources, available with various departments and agencies concerned with Growth and Development, in the most well planned and co-ordinated manner. All vertical programmes running virtually independent of each other with very little co-operation at planning, supervisory and field levels have to be integrated totally and formulate well planned and co-ordinated practical programmes. Ivan Illick says 'there is a great deal of medical capability outside the medical profession and unlimited opportunities outside formal institutions'. So the functionaries at the block level who should be the members of the Health Development Team are to be from all walks of life.

From (1) Health and Family Welfare
(2) Rural Development
(3) Social Welfare
(4) Education
(5) Non formal Education
(6) Water Supply and Sanitation
(7) Agriculture
(8) All Voluntary and Philanthropic Institutions
(9) Mass Media.

The objectives of the team will be, all the welfare activities including health is to be expanded to cover all the population, particularly the vulnerable, improving the functioning and utilisation within the present system.

All the concerned team members should be made to

(1) understand the local maternal and child health problems well to develop a cost effective health care system.

(2) Study the problems in implementing existing programmes e.g. administrative obstacles, female illiteracy and the gap in out reach services.

(3) Study the conflicts in implementing welfare programmes for mother and children. (e.g.) deep rooted cultural beliefs.

(4) Learn how to provide technical education to family members and local volunteers.

(5) Learn methods of mobilization of people in the village particularly women for promotion of health.

(6) Understand importance of documentation of health events, evaluation and accountability.

Rules and roles for the team members can be so defined as to provide built-in flexibility, within a clearly defined broad policy framework. Each block can assign responsibilities and tasks, allocate resources, and set targets according to the local priorities, health and family welfare needs of the people. (e.g.) (a) areas where nutrition status is poor nutrition input must be maximum. In most backward areas female literacy must have top priority. Many of the maladies of the present system can be cured at the village level by a very effective team by involving the family itself. The goals to be achieved also has to be streamlined. (e.g.) The short term goals of the team will be, achieving.

(a) 100% Antenatal care
100% Natal care
100% immunization coverage
100% Infant follow up.

(b) Training and educating the team in recent advances in child health care. e.g.) growth monitoring, oral rehydration therapy, breast feeding, weaning and food supplementation, female literacy and family spacing.

The overall objectives of education and information with communication programmes of the team is, to educate and mobilise the neediest sections of the rural population so that, they can themselves initiate actions to achieve and maintain an acceptable standard of health and family welfare.

The long term objectives will be-

(1) To inculcate a sense of self reliance and discipline in all segments of population, so that all four sides of the health square i.e. prevention, promotion, cure and rehabilitation are effectively handled at the local levels consistent with development in the field of medicine.

(2) To improve public health and public health services, to achieve health for all with expected reduction in mortality and morbidity.

(3) Universal education and total female literacy.

Training and education of the team and through them the community is a challenging task. It is on the ability to elevate the standards and reliance of the community the success can be judged.

Success in one area will turn up problems from an unexpected direction e.g. once malnutrition and infection is tackled, cardiovascular degenerative diseases may take an upperhand. The team also should anticipate and plan programmes for the future.

This approach will help all to move from knowledge to action.
Tomorrow is too late to help to-day's children. ☐

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Population Explosion and Health Policy— Ethics and Huamn Values

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The great importance of population explosion in the formulation of health policy is recognised by nearly all countries all over the world. The developing countries, however, consider it of paramount importance. While the highly developed countries have become somewhat lukewarm over this problem because they have controlled their populations and their people are well educated and have attained a high standard of living—the two important measures for the control of population—the need of such control for the developing countries and perhaps, most of all for India, because of its vast population is extremely urgent.

Before dealing with the subject of my address I may quote the definition of the three terms used for the main theme of the Conference.

Dr. Edmund Pellegrino defined as follows the three items, during his key-note address at a similar Conference in Athens.

—The health policy of a nation or a community is its strategy for controlling and optimizing the social uses of its medical knowledge and resources.

—Human values are the guides and justifications people use for choosing the goals priorities and means that make up that strategy.

—Ethics act as the bridge between health policy and values. Ethics examines the moral validity of the choices that must be made and seeks to resolve conflicts between values, which inevitably occur in making those choices.[1a]

One of the important factors that determines health policy, therefore, is to find out what the basic cultural, ideological, ethical and religious traditions of a nation are, and how they can be harmonised with the health needs of the nation.[1b]

Family planning which is essential for controlling population explosion, however, presents one unusual feature. While its urgent need is acknowledged almost universally, when we go into its methodologies and the choice of such methodologies—there is hardly any method which does not evoke controversy. Such controversies are based mostly on ethical, cultural and religious factors and human values which naturally show some differences in different nations and various communities. in the same nation. Legal views and laws on such matters which I think, are predominantly based on ethics and human values, also differ, to some extent in different countries. Some objections of course are based on medical grounds. It is somewhat strange that while the importance of family planning is acknowledged universally, no other subject which enjoys such universal acceptance as a basic idea evokes greater conflict with ethics and human values than family planning when you go into the details of its working.

The urgent need of family planning needs no emphasis. In India it should be regarded as number 1 national problem for unless we attain success in our population control methods, all our planning and other efforts for improving the economic condition of the population of our country and improving the lot of poverty stricken millions the majority of whom are in a state of malnutrition and for achieving the goal of "Health for All" by the year 2000 AD will go away and may practically come to nothing. Our Government is spending millions on what they call family welfare, but the question that arises in the minds of those who are unprejudiced and are willing to listen to the calculations of those who are trained in such problems, is—are our efforts showing signs of success and are they likely to bear fruit in time before the situation attains dimensions that will defy all solutions ?

The birth rate in India in 1984 was 33.8 per thousand and the death rate 12.5 per thousand. The population growth rate is thus near about 2 per cent. This means that we are adding every year 16 million human beings to our population. This according to most demographers will mean that by the year 2000 AD a year by which we are committed to "Health for All", we will have a population nearing the mark of 1 billion. It is incomprehensible that we can provide health for all if the population by that year attains as high a level as stated above. There is another adverse effect of this state of affairs that I may point out. Most demographers point out that a big portion of this population, unlike that in developed countries, where birth-rate is controlled but longevity has gone up, will be of younger people of marriageable age. The result of this inbuilt demographic momentum is that even if present family planning efforts succeed to reduce the growth rate to one per cent by the century end, the population will eventually stabilise in 2050 at 1250 millions. A delay of 20 years in reducing the growth rate to one per cent will accelerate the stabilised figure to 1.9 billions and of another 20 to 2.6 billion.

To give an idea of the strains placed on the economy by unbridled population growth let us see what the impact of the 136 million population added during the seventies decade will mean. The Ministry of Health in a very modest calculation that placed the direct cost of maintaining the additional population at an average income level of 1000 per year has given the estimate of Rs. 13,500 crores as the additional annual requirement to cope with this decade's increase alone. It has been estimated that an additional resource requirement of 11,850,000 quintals of food, 180,000,000 metres of cloth, 121,000 schools, 355,000 teachers, 2,390,000 homes and 3.8 million jobs for the seventies explosion. Now through the eighties an annual 16 million is being added as opposed to the 14 million annual average of the seventies.[1]

Since 1974, the global population growth rate has declined from 2.03

to 1.67 per cent per year. In the next decade the growth rate will decline more slowly. However, the annual increase in numbers is expected to continue and may reach 90 million per year by the year 2000. Ninety per cent of that increase will occur in developing countries and at that time 6.1 billion people are expected to inhabit the earth[2].

When we come to the various methods employed for family planning, there is a big range already available, though in a country, like India, efforts are still going on so far as the research field is concerned to find a method which may have the widest possible acceptance and may be free of risk and highly efficacious. So far as the available methods of reasonably proved efficacy are concerned at one extreme is abstinence and at the other extreme is medical termination of pregnancy (M.T.P.). Abstinence, of course, can have no moral or ethical objections. It had the support of saintly personalities like Mahatma Gandhi. In fact, even some religious group[3] and their leaders which on religious grounds are fundamentally against all artificial means of family planning are not against it by what is called natural methods. Some of them have tried to find its modifications like the rhythm method which has been improved lately by finding the mucus secretion of cervix which precedes ovulation and which the woman can be taught to find for herself, and which thus indicates to her the day of ovulation. However, while such methods may have some practicability amongst the well educated, closely knit religious communities, it cannot have much utility for checking the population explosion so far as the vast mass of 750 millions (out of which 127 million couples are in the reproductive age period), are concerned. In fact, a further improvement may occur in this method, i.e., science may very soon reveal a method by which the actual day of ovulation may be found out by simple tests, yet even then human nature and instincts as they are it will not make this method feasible so far as the control of population explosion is concerned. So, while some communities and religious groups and their leaders are still advocating it, we may not discuss it further in a limited address.

The methods of family planning and contraception are so numerous that I cannot discuss the ethical and human values of all of them, but I may select three items which have evoked or are likely to evoke the maximum controversy on grounds of ethical and human values and their interconnected legal aspects. They are : (1) Enforcement of a policy of limited number of children by various types of legislative measures, (2) voluntary sterilisation and (3) M.T.P. (Medical Termination of Pregnancy).

China by launching a one-child policy claims to have achieved a spectacular success in their family planning programmes and restriction of population growth. Some independent observers have confirmed this claim. Though India was the first country to adopt family planning as an official programme and can claim some reduction in birth-rate, its population growth is still maintaining an alarming tempo. Can we, as also the other democratic developing countries of the world, achieve success in time to limit our population to such a level that it will not affect our economic growth and other programmes for prosperity and removal of poverty ? This raises a highly ethical and legal question for a conference like this. In such democratic countries, especially in India, the rights of an individual reign supreme. They cannot be interfered with except to a limited extent in the event of a war or threat to national security, even though as is evident from the details that I have given above, the issue of family planning upon which future prosperity and stability of the country depends is of no less importance than the destruction caused by an actual war. However, unlike wars—speaking in medical terms it is not a question of sudden death but a lingering existence of starvation and malnutrition for millions. All the same a question arises, "Can any democratic Government impose its will and order that no family can have more than two children and impose penalties if this rule is violated ?" If we find at some stage that our present developmental schemes and plans are not bearing fruit and the deluge in population seems to destroy all hopes of health, prosperity and well-being of our future generations, can we have legislation in which the state in this particular matter of number of children in a family impose its will on the people ?" This would actually mean that because of an emergency we make the rights of an state or the nation as a whole supersede the rights of an individual. Individual human values and rights in practice if not in a written law include right freely to choose the time of marriage (subject to legal minimal ages); the right to decide on the number and spacing of children in the family (the right to contraception) and to decide about one's own body in relation to this (sterilisation and abortion, within existing legal constraints)[4].

As an alternative to the above type of legislation which would be repugnant to principle of human rights, can the great legal experts make some other suggestion which *may make people limit their* families and thus ensures progress and prosperity.

Let us, however, hope that the contingency for enacting the above type of legislation or some similar action will not arise. In facts, at the 1984 United Nations International Conference on Population in Mexico City there was still some difference of opinion amongst nations over future policies. For example, while the Vice President of Kenya told the meeting that the world "cannot wait for the crisis of over-population to right itself through economic development" the United States delegation presented an opposing view and gave examples of Hong Kong and South Korea which though had scarce natural resources had made swift progress by relying on the creativity of private individuals working within a free economy. However, the consensus amongst nations was that family planning is needed to supplement the effort of economic development in reducing population growth, and almost all developed and developing countries endorsed at the Mexico City Conference, family planning as an integral part of development, and acknowledged its contribution to the health of women and children[5].

How difficult the question of family planning is and how it is almost impossible to meet the social objections to it which will very from country to country according to their own cultures and traditions will become apparent if one goes through some of the recommendations on family planning at the Mexico City International Conference on Population held in 1984.

Recommendation 25

Governments should, as a matter of urgency, make universally available information, education and the means to assist couples and individuals to achieve their desired number of *children.* Family Planning information, education, and means should include all medically approved and appropriate methods of family planning *including natural family planning, to ensure a voluntary and free choice in accordance with* changing individual and cultural values. Particular attention should be given to those segments of the population which are most vulnerable and difficult to reach.

Recommendation 30

Governments are urged to ensure that all couples and individuals have the basic right *to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so*; couples and individuals in the exercise of this right should take into account the needs of their living and future children and their responsibilities towards the community.

Recommendation 31

Legislation and policies concerning the family and programmes of incentives and disincentives *should be neither coercive nor discriminatory and should be consistent with internationally recognised human rights* as well as with changing individual and cultural values.

Recommendation 33

Governments that have adopted or intend to adopt fertility policies are urged to set their own quantitative targets in this area. Countries implementing family planning programmes should establish programme targets at the operational level, *respecting the basic right of couples and individuals to decide freely and responsibly the number and spacing of their children, taking into* account the needs of their living and future children and their responsibilities, *exercised freely and without coercion, towards the community.*[6]

You can see how carefully these recommendations are worded and how carefully that organisation has avoided objections from any country on social and ethical grounds. For various countries according to their own culture may have their own objections. They are giving in every one of these paragraphs precedence to human rights. But will developing countries attain appreciable success under these conditions.

It is, apparent that while a vast number of countries especially the developing ones are in favour of family planning, there are objections on social, human, ethical and legal grounds from Nations and communities in the same nation and every question concerning the family planning becomes a complex one. It is for the various learned speakers who will be taking up various aspects of this subject to throw light on some of the points that I have raised.

The next item that I may take up is of voluntary sterilisation. In the beginning there was a lot of opposition to it in many of the well developed countries on certain moral grounds, as the opponents said that it amounts to mutilation of the human body either in the man or the woman, i.e., vasectomy in males and tubectomy in females. Moreover, there was opposition to it because it is irreversible. It is in fact the main method of irreversible nature—though scientists and surgeons are making efforts to make the two methods one in males and one in females reversible. Tubectomy is being done extensively now through the endoscope (laproscope). The fact that now tubectomies are being undertaken far more commonly than vasectomies, though the latter is a much easier operation almost free from risks only shows the continuing domination of man over woman which still persists in most countries.

These irreversible operations are open to one great objection and that is that why should they be resorted to when reversible methods are easily available, for if the existing off-springs die due to unforeseen circumstances the parents become issueless for ever. So, interconnected with the successes of these operations must be a sustained effort to diminish infant mortality. In developed countries where reversible methods can be easily followed by well educated couples, these irreversible methods are no longer favourites. However, in countries like India where millions and millions of couples in the reproductive age period exist and cannot be relied upon to use consistently the reversible methods, these irreversible methods have remained the most favourite with administrations. In India it is the most favourite method with the state governments. This is especially so because it ensures certainty of results. It is so far done after there have been two children unless the parents themselves volunteer to get it done earlier. Many state governments expect some sort of targets from their doctors though they may not do it openly.

In many of the well developed countries there have been long controversies over whether voluntary sterilisation (they never even dream of forcible sterilisation) should be allowed at all or not. In some countries, it is still illegal, but generally speaking in most countries a liberal view is being taken and voluntary sterilisations are either being allowed by law or at any rate being overlooked, and no prosecutions are done. In India, however, voluntary sterilisation as I have said is favoured, but there is a strong public opinion against forcible sterilisation which a democratic country like India will never allow whatever the needs of the country may be. This raises, in fact, again the question of individual rights versus the right of the State to impose its will. However, we should avoid reaching that stage.

The guidelines protecting voluntarism and ensuring safety should, however, take priority over more administrative matters.

The most pressing ethical and legal issue today is how to ensure that sterilisation is 'voluntary' in the sense that the decision to be sterilised is one which is informed and unpressurised. (7)

As regards the reversible methods, the main difficulty is whether they are acceptable and most easily available to our masses of rural population, quite a lot of whom are not educated enough to understand the utility and proper applicability of these methods. Out of these methods, the main controversy lies as regards MTP and certain ramifications of this method which I will mention later.

For the sake of avoiding unnecessary objections, it has now been termed Medical Termination of Pregnancy (MTP) and the word abortion is hardly ever used. Feelings in certain countries are so strong on this question that in the last International Population Conference in Mexico, USA made the banning of abortion as a measure of population control a central condition for its population assistance. Moreover, laws for termination of pregnancy raise another ethical question—'has a foetus a personality'. If it has a personality, it naturally has rights.

According to the latest Indian law on medical termination of pregnancy, such termination has been made permissible under certain conditions. The Indian law was enacted in 1971 to protect the women's rights, if there was a fear that future physical or mental health of a woman is imperilled if pregnancy continues. In this connection one out of the various clauses that allow termination may be quoted :—

1. If the continuance of the pregnancy would involve a risk to the life of the pregnant women or of grave injury to her physical or mental health.

Inclusion of mental health, in fact, makes the attitude of law towards termination quite liberal but reasonable, for any unwanted pregnancy is going to have psychological effects on the mother. Explanation of the above clause states :

> "Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant women."

This explanation makes the permission liberal indeed and almost any case who has been making attempts to use cuntraceptives can come under it.

Though the above law was enacted for a different purpose, it must be conceded that indirectly it may help population control, as a sizeable number of patients in whom contraception fails will in all sincerity take recourse to it. However, it must be acknowledged that MTP as a means of population control means a failure of contraception either due to carelessness or due to chance or due to ignorance. We must, however, see the other side of the picture, also. If it is not made permissible under the law, the acts of termination will go into the heads of the unqualified persons which means a very high increase in complications and even fatalities. Such cases have been quite frequent in many countries including India. That in itself is a big justification for evolving the present law on medical termination of pregnancy. In fact, in the short run it has been said that a desire for effective contraception also leads to an increase in abortions. Because of this inter-ralationship, contraceptive and abortion services need to be linked.[8]

I think there will be no difference of opinion as regards the necessity of MTP when the future physical health or the life of the mother is in danger for you have to save one of the two lives and the mother's life is no doubt more valuable of the two. Even the most conservative and religious minded persons will not contest it. However, considerable differences of opinion arise when we consider the mental health and future psychological state as a result of an unwanted pregnancy. For a doctor, however, future mental health is as important as physical health. However, such a justification does give considerable handle for malpractices.

The opposition to MTP as a means of population control is, however, understandable. When other effective methods of family planning are available, why should we destroy a life just because a couple has been negligent and did not practise the method properly. So, they argue on ethical grounds that induced abortion should not be included as a method of population control especially as it destroys a life which legally speaking has a personality of its own and we have thus, no right to destroy it. However, the protagonists of MTP who want it to be included as a plan in family planning argue that as no contraceptive method is infallible, an unwanted pregnancy should be terminated and, so, I understand certain countries are very liberal about MTP. They further argue that the population control for developing countries is a national need which should be treated as an emergency and must supersede all other considerations. Moreover, when laws to prevent induced abortions are made more strict it only leads to the emergence of quacks and secret abortions which increase manifold the risks to the health and life of the mother. Thus, on this ticklish question of MTP which involves moral values and religious and ethical beliefs a consensus of medical and legal opinion is needed as to how liberal the legislation should be to allow MTP as a legitimate method of family planning without leading to immorality and sexual promiscuity, especially at the level of very young age groups. As I have said above, if it is not liberalised it only leads to abuses and going to quacks. The major problem, therefore as regards moral and legal issues involved in MTP is one of proper implementation.

All that I have said above, of course, does not obscure the fact that the debate over abortion, even in countries where the law has been reformed, is a passionate one.[9]

A few related questions may be discussed at this stage. With the advances in medical sciences, especially ultra-sound examination and amniocentesis, it is possible in some cases to see if the future child is going to have physical or mental abnormality. What should be the criteria of judging which deformity or abnormality, physical or mental, is going to be so serious that termination of pregnancy is justified. Divergences of opinion are bound to occur. But it is for medical men and social workers to devise criteria for allowing MTP in such cases. However, a more serious problem is arising in this country and may be in some other countries. It has become possible by the above methods to find out the sex of the future child. As a theoretical or purely scientific exercise it is interesting but the knowledge of that to parents is likely to be used for one purpose, especially in families which have a preponderance of female offsprings. They will utilise the knowledge for secret termination of pregnancy if the foetus is found to be a future female child. This means in a way reverting to the age old highly unethical practice long since prohibited by law of female infanticide. Rather than to take this risk, will it not be better to prohibit by law the emergence of laboratories which reveal this knowledge to the parents in early stages of pregnancy.

If induced abortion is to be considered strictly from the moral and religious angle then certain reversible methods may actually be leading to the induction of abortion but are not being categorised as such. For example, MR (Menstrual Regulation) by protaglandins or by an MR syringe is certainly an abortion in a vast majority of cases. Should it be allowed even though foetal life at that stage is very early and almost invisible. Use of certain drugs may possibly be also an abortion of the foetus at a very early and almost invisible stage. If a vaccine against protein carriers of vitamins to the foetus becomes successful that will also be abortion at a very early stage of the foetus—only killing it before it become even recognisable as a foetus. So, if religious and ethical and moral considerations prevail there will be objection to such methods also which are ordinarily regarded as methods of contraception but are really abortions at a very early stage before the foetus becomes even anatomically visible to the naked eye.

There are many reversible methods of contraception such as condoms, pills, insertion of copper T etc., long acting injectables, some herbal medicines such as gassypol—a Chinese herbal medicine for males—and coitus interruptus. There are not likely to be any ethical objections to such methods except by the most conservative and religious groups who do not want any interference of the natural process, but there can be objections to all such methods on health grounds or on grounds of inadequate acceptability. We need not discuss that.

An associated question is the question of incentives and disincentives. There have been not discussions on this question. However, the main objection which involves ethical values as regards some incentives and nearly all disincentives is that why should a third or a fourth child suffer from certain handicaps in comparison to other children who may be even less bright than him/her, because his/her parents made the mistake of not falling in line with a policy which was very important from the national point of view. Why should the sins of parents be visited on off-springs. His/her parents may deserve those handicaps but why should the child suffer who committed no fault? It is an important objection from the ethical point of view and, so, there should be no question of disincentives, thought some incentives may be chosen carefully and may help to some extent in carrying on the family planning programme specially in certain limited circles like industries etc.

There are two other issues which I cannot/take up in detail, but which are worth mentioning. *One is reducing the infant mortality.* In India it is still shamefully high. It is higher than that of many developing countries and was 104 per thousand live births in 1984. It is generally admitted that family planning is acceptable only if the infant mortality is low and most children which are born have the prospect of living a normal life. The Family Planning Foundation is in the process of investigating in collaboration with the International Development Research Centre (IDRC), Ottawa, Canada, *whether such a statement is a fact or not so far as Indian* *conditions are concerned,* and also find out the high risk factors associated with infant mortality in various areas so that the Government may be helped to mount an intervention strategy. There can obviously be no ethical or human objections to it and the lowering of infant mortality will be welcome to all communities. *The second important factor which promotes family planning is* raising the status of women. For quite a number of extra births take place because the parents want a male child. Moreover, a woman seems to have in this country only a small place in deciding the number of children that she should have. The need of raising the status of women is still felt even in the most developed countries for the opportunities for all types of employment are still less for women than what are available to males. Governments should formulate and implement concrete policies which would enhance and raise the status of women.[10]

It is a proven fact that in development countries that to the extent to which legislation ensures full and free access for women to education and to employment on terms and conditions of complete equality with men, the effect will be to reduce fertility.[11]

An important point in this connection is raising the age of marriage of the girls. If that age could be raised from 18 to 21, and sterilisation could be induced as far as possible after the age of 30 there will be a very shary fall in the number of births. According to demographers, nearly half of the births occur before the age of 20 and after the age of 30. There can be no ethical objections to raising the age of marriage in girls if it is done on the grounds of improving or saving the health of the young girls. However, legislation for this purpose is not likely to succeed and will have ethical and moral objections in addition. It means an interference with human rights of the individual.

It must be realised that there is no method of contraception which can have no objections, is absolutely safe and is fully efficacious and universally acceptable. That is why research is going on and on to find a most acceptable, most efficacious and most harmless method. However, the problem is so urgent that we cannot wait for the results of such research. Even when there are some minor objections and flaws on grounds of health and efficacy, we have to look at such problems from a different angle, i.e., greatest good of the greatest number and the acute need of the nation. So occasional small risks have to be taken.

The doctors are, of course, needed for the execution of the various methods and are key-figures in teaching the public the various techniques etc. However, they have one greater role to play and that is to mould public opinion in favour of family planning. Doctors alone cannot achieve success in family planning. If we want great results, family planning has to become a people's programme. Thus, it is necessary to develop extensively public opinion in/its favour especially at the grassroot level. The doctors come in close touch with the family and the general practitioner who is a family physician and almost a family member for most families can thus be a great factor in developing proper public opinion in favour of our family planning programme. It must be realised by all of us that family planning which may be technical easy is socially difficult and doctors can be a great factor in overcoming that social difficulty. Non-government Voluntary Organisations can also play a very great role in this direction. In fact, that should be their chief role in addition to helping the government in their programmes. Let us hope the combined efforts of the government, the medical profession and the non-goverment organisations like the Family Planning Foundation achieve significant success in the Seventh Plan so that we may succeed in our health for all programmes by the stipulated year 2000 A.D. and enter the next century in a prosperous and hopeful vein. ☐

References

1A. Edmund & Pellegrino. Key Note address at Health Policy—Ethics & Human Values Conference at Athens in 1984. Published in Highlights of Athens Conference—XVIII CIOMS, Round Table Conference, Athens 1984. Edited by John H. Bryant and Zhijniew Bankowski 1986. page 7,

1B. Robert Veatch. Some as abovel. Page 11.

1. Address by Shri B. Shankaranand, Minister of Health and Family Welfare, Government of India, at the Conference of Voluntary Organizations on Promotion of Family Welfare Prgramme.

2. Mexico City Declaration on Population and Development.

3. Ganguli, H.C. Sexual Behaviour : A New Perspective in Family planning—Publication of the Department of Psychology, University of Delhi, 1984, pages 18 and 109.

4. Law and Fertility in Europe edited by Maurice Kirk et al—Publication of the European Centre for Research and Documentaion in Social Sciences and International Union for Scientific Study of Population—1975—Preface page II.

5. Malcom Potts—Population and Politics (leading article) BMJ 1984, 289—641.

6. Ibid.

7. Law and Planned Parenthood—Edited by John Paxman for International Planned Parenthood Federation—1980, pages 38 and 59.

8. Ibid.

9. Ibid.

10. Mexico City Declaration on Population and Development.

11. Trevici, V. Law and Social Status of women—Law and Fertility in Europe (same as 4) 1975—page 97.

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A Look at Rural Surgery in Private Sector in India

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80% population in India is residing in Rural Areas, besides solving the Health and Medical problems of this population, we need to cater for their Surgical needs also. This is done by Government Sector through Primary Health Centres, and Cottage Hospitals but quite a substantial Surgical work is being done by Private Rural Surgeons.

Let us see the role of these private Surgeons in delivering surgical care in rural areas, the type of surgical practice in villages and the problems and difficulties faced by the Rural Surgeons.

This paper is based on a Study conducted in an Backward Adivasi District of Dhule in the State of Maharashtra and analysis of 5769 total Surgical operations done by the author during 18 years of his work in a small private Rural Hospital in the town of Dondaicha which is not even a Taluka place.

From the Statistical Study of the District it was found out that in 1984 total 11724 operations were done in Government Sector out of which only 3362 were done at peripheral hospitals. In private sector 11652 were done out of which 2924 were done in Rural Hospitals.

If we compare the individual work done by private General Surgeons in Dhule City proper with that done by peripheral Private Surgeons it could be seem that the City Surgeon is doing on an average two hundred operations per year, while a Peripheral Surgeon is doing more than four hundred operations per year, double the work than his colleague in City.

This is partly because the rural public is getting surgical facilities at their door steps as can be seen from the map which shows that the Government Civil Hospital which undertakes major surgical work is placed at one corner of the District almost 130 Kms. away from the farthest point to reach this hospital for free treatment, the patient who is usually poor, has to first travel by a bullock cart or a hand cart or some times in hilly areas on hands or bamboos to reach the nearest bus station and then to spend about Rs. 120/- as fare for himself and his accompanying persons, at least 2-3 relatives, and almost 2 days having a night halt somewhere, instead he prefers to pay the nearby peripheral Private Surgeon. That is why there is lot of work to do for a Private Rural Surgeon.

But the nature of Rural Surgical Practice is entirely different as compared to city practice. The patients do not differentiate between a Physician, a Surgeon or a Gynaecologist so there is more work of consultation taking major part of the Surgeons time 9 A.M. to 5 P.M. In 18 years practice there were *75060* O.P.D. patients as compared to only *5769* operations.

Emergencies are much more common in comparison to city practice and disturb the sleep of the Surgeon almost daily.

As there are no assistants, Registrars or house-surgeons to work under him even after 18 years of practice, he has to carry out minor procedures like circumcisions, suturing CLWS, opening abscesses and what not.

He has to maintain his own Nursing home for which he has to first find out a building. There are no good buildings and the hospital may have to be set up in any old building built in kachha mud, but the building can be modified and decorated at least internally using asbestos sheets or plywood to form false roof and false walls.

As there are no Pathologist the Surgeon has to keep his own Laboratory and blood Transfusion Service, and a small X-ray machine on which no special investigations are possible.

There are no facilities for frozen section biopsies.

In abscence of special investigations, clinical judgment is the most important armamentarium in diagnosis.

Coming to the operation theatre equipment, usually the rural private surgeon is coming from a poor or middle class family and cannot afford to have sophisticated equipment at least in the beginning of his career, even then he has to keep enough stock of all the materials as neither he can purchase them immediately nor can he borrow from anybody.

Maintenance of costly equipment is a problem and the Surgeon himself has to repair his own equipment using gadgets like multimeters, with the help of local technicians.

Electric supply failure is a very common event and a stand by arrangement for emergency lighting and foot operated suction machine have to be kept ready and if possible a generator set installed.

Hard water can ruin the electrical heating appliances and instruments. Ion Exchange water softners can solve the problem.

Oxygen refilling takes months to get the cylinders refilled. Industrial Oxygen available locally for welding purposes can be used safely.

Anaesthesia is a big problem. Qualified anaesthetists are not available and either wife if medico or some other local doctor has to be trained for anaesthesia or some times the Surgeon himself has to induce anaesthesia and maintain the patient on Ether bottle. In abscence of Oxygen supply the only apparatus available is on Oxford of Bellow and some kind of Ether vaporisor.

With all these the Surgeon is now ready for operation, but he has no qualified staff and nurses, the hospital staff usually consists of his wife, who should preferably be a medico, and 3-4 unqualified staff trained in the same hospital.

On the operation table the Rural Surgeon has to handle Surgical problems from any system and speciality of surgical field. The analytical data of surgical procedures carried out by author in 18 years shows that out of 5769 operations 306 were on head and Neck, 601 were of ENT, 1088 of Gastro-Intestinal tract, 534 Urological Procedures, 1423 Orthopaedic Procedure, 1585 Gynace Procedures and 302 miscellaneous operations.

Thus it can be seen that the Rural Surgeon not only has to undertake general surgical work but also orthopaedic work reducing fractures, ENT Work knocking out tonsils, gynaec work doing D & Cs and hysterectomies and obstetric work conducting difficult deliveries. In fact these three specialities form almost 65% of his surgical practice.

But usually he is qualified as a General Surgeon and has no experience of doing these operations and at least in the beginning of his career to perform any new operations is a night-mare for him.

As a Surgical Registrar the author has removed only one sided tonsil that too unofficially begging the favour of E.N.T. Registrar and had to run away leaving the operation half way as the E.N.T. boss came in.

The General Surgeon's knowledge of gynaec and obstetric operations is probably limited to whatever he has seen as under graduate sitting in the operation theatre gallery, but in his practice the Rural Surgeon not only has to do Caesarean Section but even he has to use the so called obsolete methods like craniotomy and evisceration which he has never seen in his student life.

Besides surgery the Rural Surgeon has to admit all cases needing hospitalisation like unconscious patients, patients with high fevers, convulsions, status asthmaticus, heart attacks and some times even schizophrenics. So it is urged that a Rural Surgeon should be specially trained. It is suggested that after getting basic post – graduate qualification in General Surgery, the surgeon, if wants to settle in rural areas he should be allowed to do house-posts for 6 months in Gynaecology and Orthopaedics and short posts in ENT and anaesthesia. In his basic training more stress should be given to clinical methods of diagnosis and he should be taught to handle equipments like X-ray machines and preliminary knowledge of bio-engineering and repairs and maintenance of these equipments, should also be given to him. Simpler but useful procedures, may be obsolete, in fields like anaesthesia and obstetrics should be specially taught to him to make him jack of all but Master of Surgery.

Besides all these technical and clinical Problems the Rural Surgeon has to face some social and personal problems, as already said his wife should be a medico not only because she will help him in his practice tremendously, but will not get bored in village life with no facilities for entertainment—not even good people to talk with. Children education is the biggest problem. The Surgeon has no academic life and cannot do any research, but on the whole the life is calm and quiet, people respect him all over and in due course of time he earns enough to have a good livelihood and is probably happier than in his colleagues in big cities.

That is why now more and more surgeons are coming to villages and settling at peripheral places as can be seen from the map thus delivering surgical care at the door steps of village people. So also more and more Government agencies like Primary Health Centres and Cottage Hospitals are recently being set up improving the medical facilities in rural areas. That is why now it is rare to see gangrenous hands due to tight plaster unreduced dislocations with nerve palsies, patients with huge hernia, and advance breast lesions, intestinal perforations with shock, bladder stones with recto-vesical fistulae, huge ovarian cysts occupying all the abdominal cavity sometimes with bleeding gynaec problems brought in almost exsanguinated state and ruptured uteruses due to obstructed labour, a seen commonly encountered by the author in the Seventies.

Blind faith is also disappearing fast and now it is rare to see a moribund child with branding marks all over abdomen, holy ash applied to this fore head and a sacred thread tied to his wrist. Even Adivasies now bring their young-ones not only for emergencies but also for routine Surgical treatment.

Even then a lot needs to be done to achieve the goal of "Health for all by 2000 AD" especially in rural areas. Government agencies alone may not be able to fulfil this goal. The private surgeons have a big role to play in the coming future in achieving this target, therefore it is urged that more and younger surgeons should come forward and settle in villages thus serving the masses and helping the nation and the mankind as a whole. □

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SO: JAMA. 1997 Sep 10; 278(10): 851-7
This source is Available in S.J.M.C Library
Call Number: From: 1918+
LA: ENGLISH
AB: OBJECTIVE: To provide clinical guidelines for primary care physicians who are dealing with domestic abuse and who have both the abused woman and her partner as patients. PARTICIPANTS: A 15-member expert panel with members having experience in family practice, gynecology, emergency medicine, medical ethics, nursing, psychology, law, and social work; an 11-member consulting group with members representing medicine, consumers, police, psychology, social work, and nursing; and participants from focus groups including 48 previously abused women and 10 previously abusive men. Members of the expert panel and the consulting group were recruited by the research team. Focus group members were recruited through the agencies from which they were receiving services. EVIDENCE: Available research information, and opinions of the expert panel, the consulting group, and the focus group participants. CONSENSUS PROCESS: Scoring of 144 clinical scenarios was performed by the expert panel using a modified Delphi technique involving 4 iterations. Scenarios were rated in terms of best practice for primary care physicians dealing with suspected and confirmed cases of physical abuse. Consulting group members and focus group participants then commented on the panel's results. Final guidelines were approved by the panel and the consulting group, with comments reserved in the guidelines for information from focus group participants. CONCLUSIONS: It is not a conflict of interest for the physician to deal with abuse of the female partner when both partners are patients. Both patients have a right to autonomy, confidentiality, honesty, and quality care. Patients should be dealt with independently, thereby facilitating assessment of the magnitude and severity of the victim's injuries. Physicians should not discuss the possibility of domestic abuse with the male partner without the prior consent of the abused female partner. Joint counseling is generally inadvisable and should be attempted only when the violence has ended, provided both partners give independent consent and the physician has adequate training and skills to deal with the situation without escalating the violence. If the physician feels unable to deal effectively with either patient because of the dual relationship, referral to another qualified physician is preferred.

10 of 30

TI: Detention of persistently nonadherent patients with tuberculosis [see comments]
AU: Oscherwitz-T; Tulsky-JP; Roger-S; Sciortino-S; Alpers-A; Royce-S; Lo-B
AD: Program in Medical Ethics, University of California, San Francisco, USA.
SO: JAMA. 1997 Sep 10; 278(10): 843-6
This source is Available in S.J.M.C Library
Call Number: From: 1918+
LA: ENGLISH
AB: CONTEXT: Patients with tuberculosis (TB) who are persistently nonadherent to treatment present a public health risk. In 1993, California created a new civil detention process and allowed detention of noninfectious but persistently nonadherent patients. OBJECTIVES: To determine (1) which patients TB controllers attempt to detain, (2) how often and where patients are detained, and (3) how many of these patients complete TB treatment. DESIGN: Case series with cross-sectional comparison to other adult TB patients in the study counties. SETTING: Twelve California counties with the largest number of new TB cases reported in 1994. SUBJECTS: All patients whom TB controllers sought to detain during 1994 and 1995 because of persistent nonadherence to treatment. DATA SOURCES: Public health records, interviews with county TB officials, and Reports of Verified Cases of Tuberculosis to the California Tuberculosis Control Branch. RESULTS: Tuberculosis controllers sought the civil detention or arrest of 67 patients during the study period (1.3% of adult TB patients with the same disease sites). Forty-six percent of these patients were homeless, 81% had drug or alcohol abuse, and 28% had mental illness. Tuberculosis controllers

sought civil detention of 15 patients. Fourteen patients were detained (median length of detention, 14.5 days). Tuberculosis controllers sought to arrest 62 patients during the study period. Fifty-three patients were arrested (median time in jail, 83 days). In 10 cases, both civil and criminal detention were attempted. We analyzed completion of therapy after excluding patients who were not detained or who died or moved. Overall, 41 (84%) of the remaining 49 detained patients completed therapy. Of the patients who completed therapy, only 17 were detained until treatment was completed. Compared with other TB patients in these counties, detained patients had 4 times the proportion lost to follow-up and half the proportion completing therapy within 12 months. CONCLUSION: Further improvements in the care of persistently nonadherent patients may require more psychosocial services, appropriate facilities for civil detention, and detaining patients long enough to assure completion of treatment.

11 of 30

TI: Managed care in obstetrics.
AU: Devoe-LD
AD: Department of Obstetrics and Gynecology, BAA 700, Medical College of Geargia, Augusta 30912, USA.
SO: Curr-Opin-Obstet-Gynecol. 1997 Aug; 9(4): 258-61
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Managed care has marched relentlessly through all fields of obstetric care: individual and group practices, proprietary hospitals and academic medical centers, and public health systems. Emphasis on cost containment while preserving high quality has driven the redesign of healthcare delivery. A number of models for providing effective and less expensive obstetric care are now being examined in the USA and abroad. Increased market penetration by managed care will also exert profound and possibly harmful effects on traditional academic teaching institutions. These organizations must adapt to this new environment or face the erosion of physician support and training bases. Ultimately, significant moral and ethical dilemmas will arise when patients' best interests for care are being continually brought into conflict with the physician's need to earn a living.

12 of 30

TI: Unethical trials of interventions to reduce perinatal transmission of the human immunodeficiency virus in developing countries [see comments]
AU: Lurie-P; Wolfe-SM
AD: Public Citizen's Health Research Group, Washington, DC 20009, USA.
SO: N-Engl-J-Med. 1997 Sep 18; 337(12): 853-6
This source is Available in S.J.M.C Library
Call Number: From: 1945+
LA: ENGLISH

13 of 30

TI: The ethics of clinical research in the Third World [editorial; comment]
AU: Angell-M
SO: N-Engl-J-Med. 1997 Sep 18; 337(12): 847-9
This source is Available in S.J.M.C Library
Call Number: From: 1945+
LA: ENGLISH

14 of 30

TI: [Public health in transition--a social science perspective]
AU: Kuhn-H
AD: Wissenschaftszentrum Berlin fur Sozialforschung.
SO: Gesundheitswesen. 1997 Apr; 59(4): 213-6
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH

15 of 30

TI: [Ethics and economic imperatives in the distribution of care]

AU: Rorive-G

AD: Service de Nephrologie-Hypertension, Universite de Liege.

SO: Rev-Med-Liege. 1997 Jun; 52(6): 412-6

this source is not Available in S.J.M.C.Library

LA: FRENCH; NON-ENGLISH

16 of 30

TI: Ethical, social, and legal issues surrounding studies of susceptible populations and individuals.

AU: Soskolne-CL

AD: Department of Public Health Sciences, University of Alberta, Edmonton, Canada. colin.soskolne@ualberta.ca

SO: Environ-Health-Perspect. 1997 Jun; 105 Suppl 4: 837-41

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: Calls for professional accountability have resulted in the development of ethics guidelines by numerous specialty and subspecialty groups of scientists. Indeed, guidelines among some health professions now address vulnerable and dependent groups: but these are silent on issues related to biomarkers. In parallel, attention has been drawn to human rights concerns associated with attempts to detect hypersusceptible workers, especially in democratic countries. Despite this, concern for vulnerable populations grows as advances in biomarker technology make the identification of genetic predisposition and susceptibility markers of both exposure and outcome more attainable. In this article, the principles derived from the ethical theory of utilitarianism provide the basis for principle-based ethical analysis. In addition, the four principles of biomedical ethics--respect for autonomy, beneficence, nonmaleficence, and social justice--are considered for biomarker studies. The need for a context in which ethical analysis is conducted and from which prevailing social values are shown to drive decisions of an ethical nature is emphasized; these include statutory regulation and law. Because biomarker studies can result in more harm than good, special precautions to inform research participants prior to any involvement in the use of biomarkers are needed. In addition, safeguards to maintain the privacy of data derived from biomarker studies must be developed and implemented prior to the application of these new technologies. Guidelines must be expanded to incorporate ethical, social, and legal considerations surrounding the introduction of new technologies for studying susceptible populations and individuals who may be vulnerable to environmental exposures.

17 of 30

TI: Can data collection during the grieving process be justifiable?

AU: Robertson-J; Jay-J; Welch-S

AD: Division of Public Health and Primary Health Care, University of Oxford.

SO: Br-J-Nurs. 1997 Jul 10-23; 6(13): 759-64

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: Research has shown that there are a number of competing theories regarding the use of bereaved people for research purposes. One view emphasizes their vulnerability, weakness and inability to take part in decision-making. Another is that there is an infringement of rights if people are denied the freedom of choice to take part in research. This article considers issues concerned with data collection from recently bereaved relatives who were at some stage of the grieving process. The participants were interviewed as part of the OXMIS study which aimed to identify the incidence of myocardial infarction in Oxfordshire. A total of 142 interviews took place (59 home visits and 83 telephone interviews). Of the cases not interviewed, sufficient information was gained in 94% from other sources to fulfil the required criteria. The perceived benefit or apparent risk of vulnerable groups participating in research is discussed in light of the study results.

18 of 30

TI: An ethical dilemma in rabies immunisation.
AU: John-TJ
AD: Christian Medical College, Vellore, India.
SO: Vaccine. 1997 Spring; 15 Suppl: S12-5
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Rabies continues to be an important public health problem in India and many other developing countries. In India, annually some 700,000 persons are given post-exposure vaccine prophylaxis using Semple (sheep brain) vaccine. It is manufactured by government institutions and given free to the public. It is presumed to be cheap, although the actual cost of production may not be low. However, it is not a safe vaccine as it causes demyelinating central or peripheral nervous system side-effects in 1/3000-7000 persons vaccinated; this adverse reaction is occasionally fatal. Cell culture rabies vaccines are also available in India; unlike the Semple vaccine they are safe and can be used for pre-exposure vaccination, but they are more expensive. The dilemma is whether it is ethically acceptable to continue to use the Semple vaccine in humans while safer products are available. What is urgently needed is a decision tree which would enable economical use of cell culture vaccines together with the backing of professional bodies in medical practice, who will declare that cost is not the only factor in choosing a rabies vaccine-safety is also of paramount importance. We must also strive to reduce the cost of cell culture vaccines.

19 of 30

TI: [Linking of individual data. Methods of linkage]
AU: Rumeau-Rouquette-C
AD: Unite 149 de l'INSERM, Paris.
SO: Rev-Epidemiol-Sante-Publique. 1997 Jun; 45(3): 248-56
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH
AB: This paper gives an overview of linking methods of personal data computed in different files as registers and administrative or medical records. Epidemiological and demographic examples are studied, then the successive steps of record linkage are described:definition and choice of identifiants, searching and comparing pairs of records to determine whether they should be linked. A special mention is made to probability matching and methods optimizing the matching procedures. The discussion envisages the advantages of record linkage:better use of health statistics, new types of epidemiologic studies. The ethical problems and the need for evaluation are also discussed.

20 of 30

TI: Invited commentary: on the role of ethics committees in epidemiology professional societies.
AU: Coughlin-SS
AD: Department of Biostatistics and Epidemiology, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA, USA.
SO: Am-J-Epidemiol. 1997 Aug 1; 146(3): 209-13
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH

21 of 30

TI: Ethical review is needed for public health studies [letter]
AU: Allander-E
SO: Public-Health-Rep. 1997 Jul-Aug; 112(4): 266
This source is Available only few issues in S.J.M.C. Library
Call Number: From:1949-1984
LA: ENGLISH

22 of 30

TI: [The reduction of mother-child transmission of HIV infection in developing countries: potential intervention strategies, obstacles to implementation and perspectives. The Reduction of Mother-Child Transmission of HIV Infection in Africa Group]
AU: Meda-N; Msellati-P; Welffens-Ekra-C; Cartoux-M; Leroy-V; Van-de-Perre-P; Salamon-R
AD: Centre Muraz, Organisation de coordination et de cooperation pour la lutte contre les grandes endemies (OCCGE), Burkina Faso.
SO: Sante. 1997 Mar-Apr; 7(2): 115-25
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH
AB: Mother to child transmission (MCT) of Human Immunodeficiency Virus (HIV) is the main cause of the spread of the HIV epidemic in the pediatric population. It is estimated that to date, three million children worldwide have been infected by HIV. The epidemic burden in developing countries is dramatic. Ninety-five percent of the world's HIV-infected women are living in developing countries. In industrialized countries, antiretroviral treatment of pregnant women and newborns with azidothymidine (AZT, ACTG 076 regimen) and discouraging breast feeding by HIV-infected mothers are effectively reducing MCT of HIV. However, there are three major obstacles to the systematic application of these strategies in developing countries: (a) difficulties in implementing the complex AZT administration and its corollary the avoidance of breast feeding; (b) the complexity of the logistics of the ACTG 076 regimen; (c) cost. Indeed, in developing countries the socioeconomic situation of the populations are precarious and health structures and services are underdeveloped. In addition, the anxiety and the reluctance of general population in the face of the HIV problem and the high prevalence of maternal anemia reduce the acceptability and safety of AZT treatment for pregnant women in developing regions. Only interventions that are applicable, acceptable, safe, affordable, of low cost and integrated into health system will be able to reduce HIV MCT. We now know that MCT occurs mostly during the perinatal period and the maternal viral load in blood, in cervical secretions and in breast milk appears to be the main determinant of transmission. Maternal vitamin A deficiency may also favor MCT of HIV. It is however possible that this association is confounded by the relationship between advanced maternal HIV disease (a known risk factor for transmission) and vitamin A deficiency. In spite of these uncertainties concerning determinants of MCT of HIV, several interventions have been designed. The first involves treating the mother with antiretroviral drugs for the perinatal period. The second is vaginal disinfection by application of virucidal antiseptics during the perinatal period. The third is to give vitamin A supplements to pregnant women and children. Finally, passive immunotherapy with anti-HIV antibodies applied to pregnant women and/or new born, may be beneficial. The feasibility, safety and efficacy of these potential interventions have not yet been demonstrated in developing countries. In view of the dramatic spread of HIV infection in these countries, the evaluation of these interventions is of utmost priority. These trials are necessary because of the public health emergency but should be performed in strict respect of human rights and medical ethics.

23 of 30

TI: Maintenance of professional privilege as exits in France.
AU: Gromb-S
AD: University of Medicine of Bordeaux, Public Health Department, France.
SO: Med-Law. 1997; 16(2): 395-404
this source is not Available in S.J.M.C.Library
LA: ENGLISH

24 of 30

TI: Epilepsy and the law-medical records.

AU: Mallon-L
AD: NSW Medical Defence Union, Australia.
SO: Med-Law. 1997; 16(2): 245-52
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This paper reviews the need to keep medical records and concludes that Section 126 of the New South Wales Medical Practice Act, 1992, requires such provision to comply with adequate "professional conduct". This was above and beyond other possible mandatory maintenance of appropriate records, such as may be covered by the notifiable diseases provisions of the Public Health Act. Ethical codes of conduct imposed further obligations to maintain appropriate records, and legal defence against claims of misconduct or negligence required documented evidence to refute false accusations. The emphasis of records has changed with greater need to stipulate risk exposure associated with proposed treatments and advice provided for such things as necessary follow-up. It was further shown that appointment diaries, extra file entries and indications of any failed attendance and resultant subsequent actions were all part of adequate record-keeping. Finally, the paper reviews ownership of medical records and refers to the New South Wales case of Ms Breen, in which it was found that ownership of records, as at the printing of this paper, resided with the doctor.

25 of 30

TI: Registered nurses' knowledge and compliance with regulations relating to the administration of ward recordable medications.
AU: Gill-BI; Bligh-JA
AD: Division of Public Health, Faculty of Health, University of Western Sydney, Macarthur, Campbelltown, New South Wales, Australia.
SO: Int-J-Nurs-Pract. 1995 Nov; 1(1): 43-51
LA: ENGLISH
AB: An anonymous questionnaire assessing nurses' knowledge, attitude and compliance with legally mandated regulations relating to the administration of ward recordable drugs was administered by mail to a random sample of nurses registered in New South Wales, Australia. Sixty-four per cent of subjects (n = 318) responded. Both self-reported and colleague-reported compliance rates were less than 50%. A highly significant relationship was evident between knowledge and attitude, knowledge and reported compliance; and attitude and reported compliance. Factors that may influence non-compliance are discussed and the legal, ethical and policy implications of the findings are briefly explored.

26 of 30

TI: Ethical dilemmas in current planning for polio eradication [see comments]
AU: Taylor-CE; Cutts-F; Taylor-ME
AD: Department of International Health, Johns Hopkins School of Hygiene and Public Health, Baltimore, MD 21205, USA.
SO: Am-J-Public-Health. 1997 Jun; 87(6): 922-5
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH
AB: Intensification of polio eradication efforts worldwide raises concerns about costs and benefits for poor countries. A major argument for global funding is the high benefit-cost ratio of eradication; however, financial benefits are greatest for rich countries. By contrast, the greatest costs are borne by poor countries; the Pan American Health Organization has estimated that host countries bore 80% of costs for polio eradication in the Americas. The 1988 World Health Assembly resolution setting up the Polio Eradication Initiative carried the proviso that programs should strengthen health infrastructures. Drastic cuts in donor funding for health make this commitment even more important. Two international evaluations have reported both positive and negative effects of polio and Expanded Programme on Immunization programs on the functioning and sustainability of primary health care. Negative effects

were greatest in poor countries with many other diseases of public health importance. If poor countries are expected to divert funds from their own urgent priorities, donors should make solid commitments to long-term support for sustainable health development.

27 of 30

TI: Comment: ethical dilemmas in worldwide polio eradication programs [comment]
AU: Sutter-RW; Cochi-SL
AD: National Immunization Program, Centers for Disease Control and Prevention, Atlanta, Ga, USA.
SO: Am-J-Public-Health. 1997 Jun; 87(6): 913-6

LA: ENGLISH

28 of 30

TI: Ethics in public health practice: a survey of public health nurses in southern Louisiana.
AU: Folmar-J; Coughlin-SS; Bessinger-R; Sacknoff-D
AD: Department of Health Systems Management, University School of Public Health and Tropical Medicine, New Orleans, Louisiana, USA.
SO: Public-Health-Nurs. 1997 Jun; 14(3): 156-60

LA: ENGLISH
AB: The present study was designed to help learn more about the ethical interests and concerns of public health nurses employed in state and local health departments. Self-administered postal questionnaires were mailed to 41 public health nurses employed at health units in Region I of the Louisiana Office of Public Health. Basic demographic information was obtained along with information about the workers' previous instruction or training in ethics and the nature of ethical conflicts encountered in their public health practice. Only 38% (15 of 39) of the surveyed nurses had had formal instruction in ethics. Even fewer (7.3%) had received continuing education on ethics. Most of the nurses felt confident in their ability to recognize an ethical conflict or dilemma in the workplace; fewer felt confident in their ability to resolve an ethical conflict or dilemma. A high proportion of the nurses agreed that there is a need for continuing education courses on ethics for public health workers. Nurses who had received formal ethics instruction were more likely to feel confident in their ability to recognize an ethical conflict in their public health practice. Continuing education programs on ethics are needed that are designed to meet the specific needs of front-line public health workers.

29 of 30

TI: Confidentiality and the acquired immune deficiency syndrome (AIDS): an analysis of the legal and professional issues.
AU: Hayter-M
AD: Department of Community and Primary Care Nursing, University of Sheffield, England.
SO: J-Adv-Nurs. 1997 Jun; 25(6): 1162-6

LA: ENGLISH
AB: Confidentiality is one of the most significant concepts in health care and nursing practice, particularly in the arena of HIV infection and AIDS. The implications for individuals of deliberate or accidental disclosure of their HIV status can and does have far reaching effects. This paper will explore the concept of confidentiality by discussing the legal and professional issue of confidentiality and AIDS. The nature of the law and guidance by professional bodies allow exceptions to the respect of confidentiality in certain situations. AIDS and the need for confidentiality often is in conflict when public health considerations are deemed to be involved. The law is poorly developed in this area and often professional guidance is less than clear.

TI: Duration and adequacy of dialysis. Overview: the science is easy, the ethic is difficult.
AU: Kjellstrand-CM
AD: Department of Public Health Services, Bowman Gray School of Medicine, Winston-Salem, North Carolina 27157-1063, USA.
SO: ASAIO-J. 1997 May-Jun; 43(3): 220-4
this source is not Available in S.J.M.C.Library
LA: ENGLISH

AB: Because of physiologic, technical, and practical limits, short dialysis is probably associated with higher mortality when compared with longer dialysis, even when dialysis efficiency is maintained with a proportionately higher clearance. The optimal dialysis efficiency measured as KT/V (or better expressed as mean standardized urea clearance in ml/min) for hemodialysis, remains unknown, but it is not unreasonable to assume that either a KT/V of 3 or a mean standardized urea clearance of 30 ml/min is optimal, and certainly better than the presently used KT/V of 1.2 to 1.8. To achieve KT/Vs on this order, a 70 kg patient will need at least 7 hours of dialysis 3 times per week. This gives rise to an ethical problem: Should one give many patients short dialysis, or fewer patients longer dialysis? This is a question to which no easy ethical solution can be found.

PC-SPIRS 3.40 MEDLINE (R) 1998/01-1998/10

1 of 52

TI: US health journal editors' opinions and policies on research in race, ethnicity, and health.

AU: Bennett-T; Bhopal-R

AD: Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill 27599-7400, USA.

SO: J-Natl-Med-Assoc. 1998 Jul; 90(7): 401-8

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: Health research on race and ethnicity has been criticized for lacking rigor in conceptualization, terminology, and analysis. Scientific journals' editorial processes help determine research quality. This survey assessed editors' awareness of current debates, attitudes toward recent recommendations, and involvement in developing editorial policies. Twenty-nine editors of health journals with impact factors of > or = 1 (based on citation ratings) were sent a questionnaire including four key problems identified in research literature and recommendations from federal agencies; 23 (79%) responded. Seven editors relevant policies. Two had read the federal directive on racial and ethnic classification; one was aware of its current review. Most perceived the four key problems as uncommon. The majority agreed with Public Health Service recommendations on race and ethnicity research, except for analyzing effects of racism. Approximately 20% had discussed issues with co-editors, editorial boards, or reviewers. About 40% saw further discussion as beneficial; four planned to draft guidelines. Editors' potential for helping resolve problems in race/ethnicity research is not being realized. Greater participation would be beneficial to public health research and practice.

2 of 52

TI: Public health ethics and clinical freedom.

AU: Newdick-C

AD: University of Reading, UK.

SO: J-Contemp-Health-Law-Policy. 1998 Spring; 14(2): 335-64

this source is not Available in S.J.M.C.Library

LA: ENGLISH

3 of 52

TI: Can ethical management and managed care coexist?

AU: Friedman-LH; Savage-GT

AD: Department of Public Health at Oregon State University, Corvallis, USA.

SO: Health-Care-Manage-Rev. 1998 Spring; 23(2): 56-62

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: The growth of for-profit managed care organizations raises serious ethical questions for managers in these settings, such as whether contemporary business ethics are most appropriate for health care organizations or how the principles of biomedical ethics can be integrated into profit-seeking firms. A model is proposed that seeks to consolidate both business ethics and biomedical ethics into a form that is useful to health service managers.

4 of 52

TI: [Ethical issues regarding individual data collection and utilization in community health care programs]

AU: Nakamura-Y; Ojima-T; Kurosawa-M; Kikuchi-S; Inaba-Y; Niino-N; Nakamura-K

PC-SPIRS 3.40 MEDLINE (R) 1998/01-1998/10

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AU: Bennett-T; Bhopal-R
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LA: ENGLISH

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AD: Department of Public Health at Oregon State University, Corvallis, USA.
SO: Health-Care-Manage-Rev. 1998 Spring; 23(2): 56-62
this source is not Available in S.J.M.C.Library
LA: ENGLISH
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4 of 52

TI: [Ethical issues regarding individual data collection and utilization in community health care programs]
AU: Nakamura-Y; Ojima-T; Kurosawa-M; Kikuchi-S; Inaba-Y; Niino-N; Nakamura-K

AD: Department of Public Health, Jichi Medical School.
SO: Nippon-Koshu-Eisei-Zasshi. 1998 Mar; 45(3): 251-61

LA: JAPANESE; NON-ENGLISH

AB: To understand the nature of ethical issues in community-based health care programs, we conducted a mail survey of subjects who were public health nurses employed by municipal governments. The questionnaire consisted of questions about data collection, usage, disclosure, and educational experience. In 1996 we received 536 completed questionnaires which were then analyzed. Regarding who should input data into computers, the number of those who considered that municipal offices other than public health nurses would be the most appropriate for the input of examination data was the largest, followed by those who felt that contracting out was best. Many of the public health nurses considered that they needed to obtain informed consent for collection, usage and disclosure of sensitive items, such as data on HIV infection. The number of those considering that they could not disclose results of examinations to other community-based specialists in health and welfare without the subject's agreement was very high. In health examination programs, the public health nurses requested information on date of birth and occupations, but there was some hesitation in requesting the latter information. Although about a half of subjects responded that they did not require data concerning the first sexual intercourse in cervical cancer screening, 90 percent asked breast feeding history in breast cancer screening. Approximately 90 percent gave results of the examination to participants personally through personal communication or mail. Of the respondents, 40 percent reported having had educational courses on ethics while the others did not. There were some responses that reminded us of the unsatisfactory level of understanding about ethical issues, which underlined the need to emphasize importance, of including this in educational curricula.

5 of 52

TI: Physicians disciplined for sex-related offenses [see comments]
AU: Dehlendorf-CE; Wolfe-SM
AD: Public Citizen's Health Research Group, Washington, DC 20009, USA.
SO: JAMA. 1998 Jun 17; 279(23): 1883-8

LA: ENGLISH

AB: CONTEXT: Physicians who abuse their patients sexually cause immense harm, and, therefore, the discipline of physicians who commit any sex-related offenses is an important public health issue that should be examined. OBJECTIVES: To determine the frequency and severity of discipline against physicians who commit sex-related offenses and to describe the characteristics of these physicians. DESIGN AND SETTING: Analysis of sex-related orders from a national database of disciplinary orders taken by state medical boards and federal agencies. SUBJECTS: A total of 761 physicians disciplined for sex-related offenses from 1981 through 1996. MAIN OUTCOME MEASURES: Rate and severity of discipline over time for sex-related offenses and specialty, age, and board certification status of disciplined physicians. RESULTS: The number of physicians disciplined per year for sex-related offenses increased from 42 in 1989 to 147 in 1996, and the proportion of all disciplinary orders that were sex related increased from 2.1% in 1989 to 4.4% in 1996 (P<.001 for trend). Discipline for sex-related offenses was significantly more severe (P<.001) than for non-sex-related offenses, with 71.9% of sex-related orders involving revocation, surrender, or suspension of medical license. Of 761 physicians disciplined, the offenses committed by 567 (75%) involved patients, including sexual intercourse, rape, sexual molestation, and sexual favors for drugs. As of March 1997, 216 physicians (39.9%) disciplined for sex-related offenses between 1981 and 1994 were licensed to practice. Compared with all physicians, physicians disciplined for sex-related offenses were more likely to practice in the specialties of psychiatry, child psychiatry, obstetrics and gynecology, and family and general practice (all P<.001) than in other specialties and were older than the national physician population, but were no different in terms of board certification status. CONCLUSIONS: Discipline against physicians for sex-related offenses is increasing over time and is relatively severe, although few physicians are disciplined for sexual offenses each year. In addition, a substantial proportion of physicians disciplined for these offenses are allowed to either continue to practice or return to practice.

6 of 52

TI: The ethics of compulsory removal under section 47 of the 1948 National Assistance Act.
AU: Hobson-SJ
AD: School of Epidemiology and Public Health, University of Manchester.
SO: J-Med-Ethics. 1998 Feb; 24(1): 38-43
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Orders for removal under Section 47 of the 1948 National Assistance Act are little discussed. However, they involve severe infringements of the civil liberties of those affected. It is argued that all previously presented justifications for the use of these orders fail. Repeal of the act is called for. The Law Commission has drafted alternative legislation, but this has not been enacted. Until this occurs local authorities, the Faculty of Public Health Medicine and individual public health physicians should refuse to be involved in its use.

7 of 52

TI: Dealing with research misconduct in the United Kingdom. An editor's response to fraudsters.
AU: Farthing-MJ
AD: Digestive Diseases Research Centre, St. Bartholomew's and The Royal London School of Medicine and Dentistry, London, E1 2AD.
SO: BMJ. 1998 Jun 6; 316(7146): 1729-31
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LA: ENGLISH

8 of 52

TI: The need for a national body for research misconduct. Nothing less will reassure the public [editorial]
AU: Smith-R
SO: BMJ. 1998 Jun 6; 316(7146): 1686-7
This source is Available in S.J.M.C Library
Call Number: From 1914+
LA: ENGLISH

9 of 52

TI: [125th anniversary of Revista Medica de Chile]
AU: Reyes-Budelovsky-H
SO: Rev-Med-Chil. 1997 Jul; 125(7): 758-60
this source is not Available in S.J.M.C.Library
LA: SPANISH; NON-ENGLISH
AB: The first issue of Revista Medica de Chile was printed in July, 1872. Since then, it has been published monthly, interrupted only for a few months during a Chilean civil war (1891). This medical journal has been devoted mainly to clinical topics in internal medicine, but currently it includes an increasing proportion of research papers in other biomedical and preclinical subjects. This journal is included in the most important international indexes of biomedical publications. Most issues cover also medical education, public health, the ethics of clinical and experimental research, medical administration and the history of medicine. The evolution of medicine in Chile along 125 years is clearly reflected in the contents of this journal. Revista Medica de Chile is one of the oldest medical journals in the world,

particularly among those published in Spanish, and a top ranking biomedical publication in Chile.

10 of 52

TI: Human research beyond the medical model: legal and ethical issues.
AU: Dickens-BM
AD: Faculty of Law, University of Toronto, Canada.
SO: Med-Law. 1997; 16(4): 687-703
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Advances in medical health depend on non-medical, as well as medical research. When research involves human participants, it raises legal and ethical concerns that have come to be approached by reference to codes of research ethics. Many of these are centered on physician-patient relationships and the pursuit of medical science. This article considers a number of issues that arise from research that follows non-medical models of research, and applications of rules of ethical medical research outside physician-patient settings. In particular, it addresses health research in the social sciences, the exclusion of women as participants in medical research, studies that depend on incomplete disclosure of information to prospective participants and their deception, and public health research based on groups and communities rather than participants as individuals.

11 of 52

TI: Cultural feasibility studies in preparation for clinical trials to reduce maternal-infant HIV transmission in Haiti.
AU: Coreil-J; Losikoff-P; Pincu-R; Mayard-G; Ruff-AJ; Hausler-HP; Desormeau-J; Davis-H; Boulos-R; Halsey-NA
AD: College of Public Health, University of South Florida, Tampa 33612, USA.
SO: AIDS-Educ-Prev. 1998 Feb; 10(1): 46-62
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: A cultural feasibility study is defined as one that investigates scientific as well as ethical, behavioral, and social issues in the design of clinical trials. The value of such a broadly defined assessment is illustrated through the presentation of two case studies conducted to prepare for clinical trials to reduce maternal-infant HIV transmission on Cite Soleil, Haiti. The first study addressed issues surrounding a trial of breast-feeding and exclusive bottle-feeding among HIV seropositive mothers. The second study focused on the implementation of a double-blind trial of HIV immune globulin and standard immune globulin to be administered to infants of seropositive mothers shortly after birth. Both cases used focus group interviews with mothers and in-depth interviews with key informants to investigate AIDS-related beliefs, acceptability of trial participation, risks to subjects, and community reactions and repercussions to the trial. Findings point to the difficulties posed by attempts to conduct trial involving complex research designs in socially disadvantaged populations. Recommendations highlight the need to consider the community-wide impact of a trial, and the need to undertake extensive educational preparation of participants to ensure informed consent and adherence to protocols.

12 of 52

TI: Human rights, not enough [letter]
AU: Dwyer-J
SO: Hastings-Cent-Rep. 1998 Jan-Feb; 28(1): 6
this source is not Available in S.J.M.C.Library
LA: ENGLISH

13 of 52

TI: Ethical dilemmas in polio eradication. Hyder responds.
AU: Hyder-AA

AD: School of Public Health, Johns Hopkins University, Baltimore, MD 21205, USA.
SO: Am-J-Public-Health. 1998 Jan; 88(1): 131-2
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH

14 of 52

TI: [The ethical problem of the health-environment relationship]
AU: Comba-P
AD: Laboratorio di Igiene Ambientale, Istituto Superiore di Sanita, Roma.
SO: Ann-Ist-Super-Sanita. 1997; 33(2): 279-84
this source is not Available in S.J.M.C.Library
LA: ITALIAN; NON-ENGLISH
AB: The need for a specific ethical evaluation in environmental health has been emphasized in recent years, with special reference to the conduction of research in environmental epidemiology, and to the subsequent implementation of public health action. Deontologic aspects that have been extensively debated include the duties of investigators towards study subjects, conflicts of interest, and rules to respect when dealing with institutions and with society at large. Epistemologic issues concern the explicitation of underlying values that influence choices in the stages of priority setting and study design. Finally, moral value is relevant whenever decision making takes place. In this frame it is recommended to refer to the core values of the public health movement, and to apply them to new, emerging problems.

15 of 52

TI: The debate over maternal-fetal HIV transmission prevention trials in Africa, Asia, and the Caribbean: racist exploitation or exploitation of racism?
AU: Bayer-R
AD: Columbia University School of Public Health, New York, NY 10032, USA.
SO: Am-J-Public-Health. 1998 Apr; 88(4): 567-70
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH

16 of 52

TI: Human rights and maternal-fetal HIV transmission prevention trials in Africa.
AU: Annas-GJ; Grodin-MA
AD: Health Law Department, Boston University School of Public Health, Massachusetts 02118, USA.
SO: Am-J-Public-Health. 1998 Apr; 88(4): 560-3
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH
AB: The human rights issues raised by the conduct of maternal-fetal human immunodeficiency virus transmission trials in Africa are not unique to either acquired immunodeficiency syndrome or Africa, but public discussion of these trials presents an opportunity for the United States and other wealthy nations to take the rights and welfare of impoverished populations seriously. The central issue at stake when developed countries perform research on subjects in developing countries is exploitation. The only way to prevent exploitation of a research population is to insist not only that informed consent be obtained but also that, should an intervention be proven beneficial, the intervention will be delivered to the impoverished population. Human rights are universal and cannot be compromised solely on the basis of beliefs or practices of any one country or group. The challenge to the developed countries is to implement programs to improve the health of the people in developing countries both by improving public health infrastructure and by delivering effective drugs and vaccines to the people.

17 of 52

TI: Immunization for prevention and treatment of cocaine abuse: legal and ethical implications.

AU: Cohen-PJ

AD: Medications Development Division, National Institute on Drug Abuse, National Institutes of Health, Rockville, MD, USA.

SO: Drug-Alcohol-Depend. 1997 Dec 15; 48(3): 167-74

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: A cocaine vaccine, currently under investigation by several laboratories, would be an innovative and exciting means of treating and preventing cocaine addiction. However, an approved vaccine will raise at least two major areas of concern. (1) Loss of privacy: cocaine antibodies might be used as a marker to identify, penalize, and stigmatize vaccinated individuals. (2) Selection for vaccination: should immunization be voluntary or compelled: should immunization be restricted to addicts, to those at risk of addiction, or should it be universal; should immunization be used in children? I propose to analogize cocaine addiction to an infectious disease which poses a major public health problem. This approach can provide an ethical and legal foundation on which we may begin to formulate a societal approach to the use of the cocaine vaccine.

18 of 52

TI: Snyder v. American Association of Blood Banks: a re-examination of liability for medical practice guideline promulgators.

AU: Noble-A; Brennan-TA; Hyams-AL

AD: Department of Health Policy & Management, Harvard School of Public Health, Boston, MA 02115, USA.

SO: J-Eval-Clin-Pract. 1998 Feb; 4(1): 49-62

this source is not Available in S.J.M.C.Library

LA: ENGLISH

AB: Medical practice guidelines are playing an increasingly important role in both the medical and the legal context. As tools for the health practitioner, it is thought that medical practice guidelines may contribute to an increase in the quality of patient care and cost-effectiveness. In the legal setting, guidelines may improve the functioning of the medical malpractice system by creating more rational, predictable standards of care. The development and promulgation of medical practice guidelines, while increasing, are still evolving. A number of concerns, especially in the areas of physician autonomy, physician control, and ethics, as well as efficacy, need to be resolved. The use of such guidelines as the legal standard of care in malpractice cases evokes similar concerns, along with fears that the use of guidelines at trial may either lower the standard of care, or, conversely, raise the standard of care to levels that are difficult to meet. Adding to this controversy is the recent case of Snyder v. American Association of Blood Banks (1996), in which the New Jersey Supreme Court upheld a jury finding that the American Association of Blood Banks (AABB) was liable to a plaintiff who contracted AIDS from an HIV-tainted transfusion, for negligent failure to adopt guidelines requiring blood testing for surrogate markers. This opinion is significant as the first to find a duty of care running from a medical guideline promulgator to a third person, the injured patient. The opinion is examined in depth and within the context of other relevant case law. The impact the opinion will have is difficult to gauge. The somewhat unique facts of the case, as well as the court's unusually stinging critique of the defendant, AABB, and its motivations informing its response to the concerns about blood contamination, may limit its value as precedent. However, precedent does exist in analogous non-medical cases for promulgator liability. The pros and cons of promulgator liability are weighed. While closer regulation of guideline development and promulgation or promulgator immunity may be warranted, it is premature to consider either seriously until the impact of the Snyder opinion can be appreciated.

19 of 52

TI: [Ethics, bioethics and medical sciences]
AU: Fontaine-M
AD: Institut oceanographique, Paris.
SO: Bull-Acad-Natl-Med. 1997 Oct; 181(7): 1477-85; discussion 1485-6
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH
AB: The aim of bioethics is to define a wise conduct for humans with regard to their environments, whether living or inanimate. However, owing to their diversity, bioethics can only deal with general problems such as biodiversity. Within the framework of bioethics as a whole, different sectorial bioethics must therefore exist to deal with problems specific to certain environments, for example the Oceans and Seas, the Forests. General bioethics and sectorial bioethics have an important contribution to make to medical sciences but official regulations should be proposed only after an attentive investigation has been made. For instance, the preservation of an apparently threatened biodiversity or the revival of a seriously damaged biodiversity must be the subject of a thorough preliminary scientific study and, if legislative decisions are taken, a very careful scientific control of their consequences must be carried out. One example is given: the decree on the protection of Larids and its impact, with regard to an abusive proliferation of certain gull populations having varied effects on public health. Sectorial bioethics can also have obvious consequences on medical sciences. Thus various harmful attacks on coral reefs (contrary to the concepts of thalassoethics) can lead to the death of corals and the appearance of ciguatera. Thalassoethics, by inciting pollution control, should help to improve the conditions of thalassotherapy. Forest ethics, particularly concerning management, can reduce the greenhouse effect and its consequences on health, as well as protecting plant and animal species inhabiting the ecosystem and bringing new chemical bodies to inspire original pharmacological research. Thus the links between general or sectorial bioethics and medical sciences must always be very close.

20 of 52

TI: Videos, photographs, and patient consent.
AU: Hood-CA; Hope-T; Dove-P
AD: Ethox, Division of Public Health and Primary Care Institute of Health Care Sciences, Headington, Oxford.
SO: BMJ. 1998 Mar 28; 316(7136): 1009-11
This source is Available in S.J.M.C Library
Call Number: From 1914+
LA: ENGLISH

21 of 52

TI: Why Australia needs minimum standards of deliberation for public health.
AU: Gaughwin-MD
AD: Department of Public Health, University of Adelaide, SA.
mgaughwi@medicine.adelaide.edu.au
SO: Med-J-Aust. 1998 Mar 2; 168(5): 228-9
This source is Available in S.J.M.C Library
Call Number: From: 1966+
LA: ENGLISH

22 of 52

TI: Projection of molecular epidemiology in medicine.
AU: Schulte-PA
AD: National Institute for Occupational Safety and Health Cincinnati, Ohio, USA.
SO: Gac-Med-Mex. 1997; 133 Suppl 1: 155-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Molecular epidemiology is a term to describe the incorporation of molecular

and other types of biomarkers into epidemiology. Molecular epidemiology uses the same paradigm as traditional epidemiology but the former represents the opportunity to use the enhances resolving power of molecular biology and contemporary biochemical science to assess exposure disease relationships. There are three types of biomarkers that can be used in this regard: They include markers of exposure, effect and susceptibility. These markers can be used as dependent and independent variables in most epidemiologic study designs. Critical in their use is that they are validated and field tested. This requires extensive collaboration between laboratory and <u>public</u> <u>health</u> scientist. Special attention also needs or be paid to the interpretation and communication of biomarker data and the ethical issues attendant to their use.

23 of 52

TI: The Dublin Principles of cooperation among the beverage alcohol industry, governments, scientific researchers, and the <u>public</u> <u>health</u> community.
AU: Hannum-H
AD: Fletcher School of Law and Diplomacy, Tufts University, USA.
SO: Alcohol-Alcohol. 1997 Nov-Dec; 32(6): 641-8
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH
AB: A 3-day Meeting held in Dublin, Ireland on 26-28 May 1997 was organized by the National College of Industrial Relations of Ireland and the US-based International Center for Alcohol Policies. During this Meeting, the 24 participants representing the beverage alcohol industry, governmental organizations and the scientific and <u>public</u> <u>health</u> communities discussed cooperation among all those concerned with alcohol consumption and its effects. These discussions led to the formulation of the 'Dublin Principles of Cooperation'. This special article describes these Principles and comments on them.

24 of 52

TI: The Dublin Principles of cooperation among the beverage alcohol industry, governments, scientific researchers, and the <u>public</u> <u>health</u> community.
AU: Hannum-H
AD: Fletcher School of Law and Diplomacy, Tufts University, USA.
SO: Alcohol-Alcohol. 1997 Nov-Dec; 32(6): 639-40
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

25 of 52

TI: [Which graft for which patient? and when? II. Organ supply and allocation]
AU: Noury-D; Claquin-J; Romano-P
AD: Praticien hospitalier d'anesthesie-reanimation, l'EfG Interregion Ouest CHRU Pontchaillou, Rennes.
SO: Rev-Prat. 1997 Nov 15; 47(18 Spec No): S22-7
<u>this source is not Available in S.J.M.C.Library</u>
LA: FRENCH; NON-ENGLISH
AB: Despite progress realised in transplantation and organ procurement, there is an increasing gap between the number of patients on the national waiting list and the number of harvested organs. As a result, the appropriate organs must be matched with the appropriate patient, with two constraints: equity and efficacy. In a context of lack of organs, another <u>public</u> <u>health</u> problematic is to conciliate both the interests of a given patient and the interests of those on the waiting lists. In 1996, the French secretary of state for health instituted a public consultation committee chaired by the vice-president of the Comite consultatif national d'ethique, Counsellor Jean Michaud, to study organ allocation rules and to plan recommendations for the future. Using, as a starting point, the allocation rules initiated in the past by France Transplant and transiently applied by l'Etablissement francais des Greffes, the committee conducted a large audition of health care professionals concerned with transplantation, individuals qualified in <u>ethics</u>, laws, sociology or ethnology,

politicians and a sample representation of the population. A new corpus of allocation rules and procedures was then defined according to the committee recommendations and the advice of all medico-surgical transplantation teams, and published as a ministerial order in the Journal officiel de la Republique francaise in november 1996. It specifies shared principles and organ by organ specific allocation rules.

26 of 52

TI: [The ethics of public health service]
AU: Diener-V
AD: Gesundheitsdepartement Kanton Zurich.
SO: Schweiz-Rundsch-Med-Prax. 1997 Dec 17; 86(51-52): 2012-5
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH

27 of 52

TI: Global disparities in health and human rights: a critical commentary.
AU: Benatar-SR
AD: Department of Medicine, University of Cape Town, Observatory, South Africa.
SO: Am-J-Public-Health. 1998 Feb; 88(2): 295-300
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH
AB: Widening disparities in health and human rights at a global level represent the dark side of progress associated with escalation of economic and military exploitation and exponential population growth in the 20th century. Even the most basic universal human rights cannot be achieved for all under these circumstances. The goal of improved population health will be similarly elusive while medical care is commodified and exploited for commercial gain in the marketplace. Recognition of the powerful forces that polarize our world and commitment to reversing them are essential for the achievement of human rights for all, for the improvement of public health, and for the peaceful progress required to protect the "rational self-interest" of the most privileged people on earth against the escalation of war, disease, and other destructive forces arising from widespread poverty and ecological degradation.

28 of 52

TI: Fifty years after the Nuremberg Nazi Doctors' Trial: reviewing how the laws of the Third Reich applied to individuals with oral clefts.
AU: Wyszynski-DF
AD: Department of Epidemiology, The Johns Hopkins School of Public Health, Baltimore, Md 21205, USA.
SO: Plast-Reconstr-Surg. 1998 Feb; 101(2): 519-27
This source is Available only few issues in S.J.M.C. Library
Call Number: From:1962+
LA: ENGLISH
AB: The Nazi Doctors' Trial, held in the city of Nuremberg 50 years ago, is a landmark in the history of medicine and science. For the first time, the horrors inflicted by a group of German scientists on innocent victims became widely known. Most of the defendants received sentences that ranged from relatively short imprisonment to death. The Trial also provided elements to develop standards for permissible medical experimentation, known as the Nuremberg Code. The atrocities judged in the Nazi Doctors' Trial, however, were not isolated. They were part of an overall eugenic system that encouraged euthanasia, compulsory sterilization, and selective marriages based on "genetic health" and "racial hygiene." Individuals with oral clefts were considered subject to these laws and suffered their consequences. This paper describes the main features of the Trial, reviews the state of knowledge on oral clefts in the 1930s and 1940s, presents how the laws of the Third Reich impacted the lives of individuals with oral clefts, and speculates on the implications of past and present eugenic policies in the future of humankind.

29 of 52

TI: [Evaluation of quality of life: a clinical challenge]
AU: Brioul-M
AD: Fondation John Bost, La Force.
SO: Sante-Publique. 1997 Sep; 9(3): 315-28
<u>this source is not Available in S.J.M.C.Library</u>
LA: FRENCH; NON-ENGLISH
AB: The possibility to estimate QUALITY OF LIFE opens new perspectives in the appraising of therapeutic results. The author suggests a scale based on a critical study of the previously known medical and psychiatric tools and some original concepts which make it useful in the field of <u>public health</u>. The estimate obtained with scale takes into account both subjective and objective data. The results bring to light the possibilities to integrate the "SIQUAV" scale (and its "DIONYSOS" application program) as complementary means for clinical reflexion and action. After a survey of the significant data obtained through the assessment and validation study (which show in all cases the importance of psychic life, relationships and social esteem), the article covers some problems relating to QUALITY OF LIFE in the context of <u>public health</u> and to its relationship with the meaning and <u>ethics</u> of therapeutic practices.

30 of 52

TI: Uncertainty in xenotransplantation: individual benefit versus collective risk [see comments]
AU: Bach-FH; Fishman-JA; Daniels-N; Proimos-J; Anderson-B; Carpenter-CB; Forrow-L; Robson-SC; Fineberg-HV
AD: Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA 02215, USA. fbach@bidmc.harvard.edu
SO: Nat-Med. 1998 Feb; 4(2): 141-4
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

31 of 52

TI: Government responses to HIV/AIDS in Africa: what have we learnt?
AU: Abdool-Karim-Q; Tarantola-D; As-Sy-E; Moodie-R
AD: Southern African HIV/AIDS International Training and Research Programme, c/o Medical Research Council, Pretoria, South Africa.
SO: AIDS. 1997; 11 Suppl B: S143-9
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH
AB: While we should not lose sight of the development of vaccines and cures, more immediate priorities include the implementation of effective STD control. The syndromic management approach developed in Zimbabwe to overcome laboratory constraints is a cost-effective way of managing STD. Of urgency is the integration of STD services into primary health-care services, appropriate training of staff, adequate provision and control over drugs and condoms, and incorporation of traditional healers and community-based education on STD. A second area of priority is the strengthening of the interaction between prevention, care and support activities, which act in synergy. Effective prevention and care require easy access to testing facilities with pre- and post-test counselling, appropriate structures and services to provide affordable and sustained care and support to those found to be infected with HIV, provision of drugs for the treatment of opportunistic infections, and the creation of a social environment and a legislation which protect against any form of discrimination the rights of people living with HIV, their sexual partners and their families.

32 of 52

TI: To tell the truth: ethical and practical issues in disclosing medical mistakes to patients [see comments]

AU: Wu-AW; Cavanaugh-TA; McPhee-SJ; Lo-B; Micco-GP
AD: Department of Health Policy and Management School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md., USA.
SO: J-Gen-Intern-Med. 1997 Dec; 12(12): 770-5
this source is not Available in S.J.M.C.Library
LA: ENGLISH

33 of 52

TI: On the use of causal criteria.
AU: Weed-DL
AD: Preventive Oncology Branch, National Cancer Institute, Bethesda, MD 20892, USA.
SO: Int-J-Epidemiol. 1997 Dec; 26(6): 1137-41
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH
AB: BACKGROUND: Two recent accounts of the use of causal criteria make opposite claims: that criteria should be used more often to avoid bias in assessments of weak associations and, in direct contrast, that criteria are scientifically invalid. METHODS: A recent review of the current practice of causal inference in epidemiology, as well as some more theoretical concerns, reveals errors in the two claims. RESULTS: In practice, epidemiologists often use the criteria of consistency, strength, dose-response, and biological plausibility, but not often temporality, when judging weak associations. These criteria are used for causal assessments as well as for making public health recommendations. In theory, causal criteria can be used to either refute or predict causal effects. CONCLUSION: Research on causal inference methodology should be encouraged, including research on underlying theory, methodology, and additional systematic descriptions of how causal inference is practised. Specific research questions include: to what extent can consensus be achieved on definitions and accompanying rules of inference for criteria, the relationship of meta-analysis to the criterion of consistency, and the interrelationships of criteria such as consistency, strength of association, and biological plausibility.

34 of 52

TI: Cardiac xenotransplantation.
AU: DiSesa-VJ
AD: Department of Cardiothoracic Surgery, Allegheny University Hospital, MCP, Philadelphia, Pennsylvania 19129, USA. disesa@auhs.edu
SO: Ann-Thorac-Surg. 1997 Dec; 64(6): 1858-65
This source is Available in S.J.M.C Library
Call Number: From: 1968+
LA: ENGLISH
AB: Heart failure is an important medical and public health problem. Although medical therapy is effective for many people, the only definitive therapy is heart transplantation, which is limited severely by the number of donors. Mechanical devices presently are used as "bridges" to transplantation. Their widespread use may solve the donor shortage problem, but at present, mechanical devices are limited by problems related to blood clotting, power supply, and foreign body infection. Cardiac xenotransplantation using animal donors is a potential biologic solution to the donor organ shortage. The immune response, consisting of hyperacute rejection, acute vascular rejection, and cellular rejection, currently prevents clinical xenotransplantation. Advances in the solution of these problems have been made using conventional immunosuppressive drugs and newer agents whose use is based on an understanding of important steps in xenoimmunity. The most exciting approaches use tools of molecular biology to create genetically engineered donors and to induce states of donor and recipient bone marrow chimerism and tolerance in xenogeneic organ recipients. The successful future strategy may use a combination of a genetically engineered donor and a chimeric recipient with or without nonspecific immunosuppressive drugs.

35 of 52

TI: [Brain death and organ transplantation: ethical dilemmas for nursing?]
AU: Windels-Buhr-D
AD: Universitatsklinikum Benjamin Franklin, FU Berlin.
SO: Pflege. 1997 Jun; 10(3): 144-50
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH
AB: According to the WHO Program, nurses should be active in public health care as equal members of a multiprofessional team. This position requires competent professional action, which also implies moral competence, especially necessitated by the coming paradigmatic changes caused by shifts in the previous and current boundaries of the paradigm human being. One reason for this shift are the greater medical technical possibilities. The medical definition of brain death as the death of a human being per se is one example of the altered boundary and its consequences. Must future components of the nursing metaparadigm be changed because of this? To what extent is nursing ethically obligated to integrate changes in social values into its metaparadigm, ethics and objectives? The nursing metaparadigm, Henderson's definition of nursing, the ICN's Basic Code of Ethics, and the nursing model according to Roper, Logan & Tierney were used as the basis in the analysis of the subject matter and problems. Furthermore, philosophical viewpoints of Jonas & Harris will be included to clarify the deontological and teleological aspects of standard ethics. Finally, conclusions are drawn about the intra- and interprofessional ethical discourse about brain death and organ transplantation among nursing professionals.

36 of 52

TI: Doctoring: University of California, Los Angeles.
AU: Wilkes-MS; Usatine-R; Slavin-S; Hoffman-JR
AD: Division of General Internal Medicine and Health Services Research, UCLA School of Medicine 90095-1722, USA.
SO: Acad-Med. 1998 Jan; 73(1): 32-40
This source is Available in S.J.M.C Library
LA: ENGLISH
AB: The Doctoring curriculum at the University of California, Los Angeles, UCLA School of Medicine covers all four years of medical school. Its goal is to train physicians to give care that is compassionate, humanistic, high-quality, and evidence-based through a longitudinal, interdisciplinary curriculum with integration of learning experiences within and between years and with more emphasis on certain topics that had been previously neglected (e.g., advanced physical diagnosis, nutrition, public health, ethics). The curriculum operates alongside the traditional one, but strong attempts are made to link the two curricula. The authors describe the gradual introduction of the Doctoring curriculum, the sometimes formidable barriers that were encountered and in some cases still exist (e.g., some faculty and student resistance, need to find funds, faculty recruitment and retention). Active, interested faculty are essential, and intensive faculty development is needed. A detailed description of each year's courses and teaching approaches is given. Year one focuses on interpersonal communication, the medical interview, human development and behavior, and the role of the community in health care; year two, on clinical reasoning, physical diagnosis skills, population medicine, and ethics; year three, on clinical problem solving, health services, professionalization issues, and prevention; and year four (which is elective), on medical education and leadership. The methods of evaluating students, faculty, and the curriculum itself are described and assessed. The authors conclude with a review of plans, prospects, and ongoing problems.

37 of 52

TI: Physician assisted suicide and the Supreme Court: putting the constitutional claim to rest.
AU: Mariner-WK

AD: School of Public Health, Boston University, School of Public Health, MA 02118-2394, USA.
SO: Am-J-Public-Health. 1997 Dec; 87(12): 2058-62
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH
AB: Like the debate about many controversial questions of ethics and medical care in America, public debate about physician assisted suicide became focused on questions of constitutional law. On June 26, 1997, the United States Supreme Court unanimously rejected any constitutional right of terminally ill patients to physician assisted suicide. An analysis of the Court's reasoning reveals that its decisions resolved only a narrow constitutional question that affects relatively few people--mentally competent, terminally ill patients who wish to hasten their imminent deaths by having a physician prescribe medication that they intend to use to commit suicide. Although suicide is not a crime, states remain free to prohibit assisted suicide. One consequence of the Court's decisions may be renewed debate on state laws. A more productive result would be to address the broader public health concerns that gave rise to support for physician assisted suicide--inadequate care for the terminally ill and prevention of suicide.

38 of 52

TI: Undercover careseekers: simulated clients in the study of health provider behavior in developing countries.
AU: Madden-JM; Quick-JD; Ross-Degnan-D; Kafle-KK
AD: Harvard School of Public Health, Boston, MA, USA.
SO: Soc-Sci-Med. 1997 Nov; 45(10): 1465-82
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The simulated client method (SCM) has been used for over 20 years to study health care provider behavior in a first-hand way while minimizing observation bias. In developing countries, it has proven useful in the study of physicians, drug retailers, and family planning services. In SCM, research assistants with fictitious case scenarios (or with stable conditions or a genuine interest in the services) visit providers and request their assistance. Providers are not aware that these clients are involved in research. Simulated clients later report on the events of their visit and these data are analyzed. This paper reviews 23 developing country studies of physician, drug retail, and family planning services in order to draw conclusions about (1) the advantages and limitations of the methods; (2) considerations for design and implementation of a simulated client study; (3) validity and reliability; and (4) ethical concerns. Examples are also drawn from industrialized countries, related methodologies, and non-health fields to illustrate the issues surrounding SCM. Based on this review, we conclude that the information gathered through the use of simulated clients is unique and valuable for managers, intervention planners and evaluators, social scientist, regulators, and others. Areas that need to be explored in future work with this method include: ways to ensure data validity and reliability; research on additional types of providers and health care needs; and adaptation of the technique for routine use.

39 of 52

TI: A proposal for the establishment of scientific criteria for health claims for functional foods.
AU: Clydesdale-FM
AD: Department of Food Science, Chenoweth Laboratory, University of Massachusetts, Amherst 01003, USA.
SO: Nutr-Rev. 1997 Dec; 55(12): 413-22
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1946-1922
LA: ENGLISH
AB: Functional foods are defined and used differently in different nations.

Health claims for these foods influence consumer behavior and potentially affect public health. In an increasingly global economy, health claims for functional foods should meet internationally agreed upon scientific criteria. The concept of health claims as it exists internationally is discussed, and suggestions to assist consumers, government, industry, and academia in deciding on a scientific and ethical basis for international agreement on health claims for functional foods are offered.

40 of 52

TI: Observational epidemiology is the preferred means of evaluating effects of behavioral and lifestyle modification.
AU: Stampfer-M
AD: Harvard School of Public Health, Boston, MA 02115, USA.
SO: Control-Clin-Trials. 1997 Dec; 18(6): 494-9; discussion 514-6
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: In evaluating the health effects of behavioral change, randomized trials have the clear advantage of being able to provide unbiased and unconfounded estimates. However, in practice, many difficulties loom that limit the utility of trials. These include the inability to assess adverse behavior (except indirectly), the often unrealistic requirement for very prolonged adherence--perhaps for decades--to the randomized assignment, the requirement for huge numbers for precise estimates of effect (as opposed to simply a "significant result"), and the ethical problem of giving a placebo when an efficacious agent is available. We must be alert to feasible opportunities to test behavioral changes in clinical trials, but the many limitations mean that we will continue to rely on well-conducted, large-scale observational studies for most of our evidence on the effects of behavioral change.

41 of 52

TI: The study of untreated syphilis in the negro male [see comments]
AU: Brawley-OW
AD: Office of Special Populations Research, National Cancer Institute, Bethesda, MD 20892, USA.
SO: Int-J-Radiat-Oncol-Biol-Phys. 1998 Jan 1; 40(1): 5-8
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: PURPOSE: The participation of minorities in clinical studies is the subject of much discussion and has even become the subject of Federal law. The project known as the Tuskegee Syphilis Study and officially titled "The Tuskegee Study of Untreated Syphilis in the Negro Male," is one of the great debacles of American medicine and a national shame. Despite the fact that its existence is well known, many do not know the historical facts of the study nor the context of the study. My purpose here is to recount the facts of the study and its historical context. METHODS: The history recounted here is taken from documents gathered during a U.S. Senate investigation of the study, original papers located in National Library of Medicine, and books about the trial. RESULTS: The trial began in 1931 as a survey of the natural history of untreated tertiary syphilis in Black men. This study enrolled 399 men with syphilis and 201 uninfected men to serve as controls. All were at least 25 years old at enrollment. The men were told they were in a study, but never educated about the implications. Later, men were not informed that there was a treatment for effective treatment for their disease--a treatment that was being withheld from them. This trial continued till 1972. CONCLUSION: Many of the issues that led to the study and caused it to continue for 40 years still exist. The lessons of the Public Health Study of Untreated Syphilis in the Untreated Negro include the dangers of paternalism, arrogance, blind loyalty, and misuse of science. "Those who do not appreciate history are condemned to repeat it" (Alfred North Whitehead).

42 of 52

TI: Defining goals and conditions for a sustainable world.
AU: Cairns-J Jr
AD: Department of Biology, Virginia Polytechnic Institute andState University, Blacksburg, VA 24061 USA.
SO: Environ-Health-Perspect. 1997 Nov; 105(11): 1164-70
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Sustainable development is being approached component by component--socioeconomic, sustainable agriculture, transportation, forestry, energy use, cities, and the like--but, leaving a habitable planet for future generations will require the development of a widely shared paradigm. Further, the paradigm should be ecological from a scientific point of view. This development will be facilitated by a discussion of goals and those conditions necessary to meet them. The presently shared paradigm is that economic growth is the cure for all of society's problems, such as poverty, overpopulation, environmental degradation, and the increasing gap between rich and poor. A paradigm shift from growth to sustainability might result either from suffering painful consequences of continuing to follow out-moded paradigms or by discussing what sort of ecosystems will be available to future generations. The purpose of this paper is to help initiate such a discussion.

43 of 52

TI: Ethical challenges posed by clinical progress in AIDS.
AU: Bayer-R; Stryker-J
AD: Columbia University School of Public Health, New York City, NY, USA.
SO: Am-J-Public-Health. 1997 Oct; 87(10): 1599-602
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH

44 of 52

TI: Ethics of xenotransplantation: animal issues, consent, and likely transformation of transplant ethics.
AU: Daar-AS
AD: Department of Surgery, College of Medicine, Sultan Qaboos University, Muscat, Sultanate of Oman.
SO: World-J-Surg. 1997 Nov-Dec; 21(9): 975-82
This source is Available in S.J.M.C Library
Call Number: From: 1977+
LA: ENGLISH
AB: The shortage of organs, breakthroughs in research, involvement of biotechnology companies, absence of ethically more acceptable alternatives, and a vaguely perceived "time to put man on the moon" feeling have contributed to the current reawakening of interest in xenotransplantation. The focus of ethical attention has changed from the moral correctness of using animals for research/therapy to an increasingly appreciated danger of the establishment and spread of xenozoonoses in recipients, their contacts, and the general public. The United Kingdom has established an embargo on clinical trials and has set up a national regulatory authority to oversee and coordinate the development of research, establish guidelines, and decide on when trials can proceed. In the United States, on the other hand, the overall attitude is to "proceed with caution," and the Food and Drug Administration has approved a number of xenotransplant studies. The Public Health Service guidelines on reducing infection risk are still evolving and are likely to end up being more cautions than they are currently. There are a number of reasons for not using subhuman primates for xenotransplantation, including their closeness to humans, the likelihood of passing on infections, their depletability (gorillas, chimpanzees), their slow breeding, and the expense of breeding them under specified-pathogen free conditions. The pig, although domesticated and familiar, is too distant to evoke the same feelings we have for primates, has the correct-size organs, is probably less likely to pass on infections, breeds

rapidly, and is not endangered; moreover, millions of them are eaten every year. Although drawing ethical conclusions is difficult, at this stage of knowledge and debate it seems acceptable to manipulate pigs genetically and to proceed to using their organs for xenotransplantation trials when infection control measures and the scientific base justify it. The question of informed consent is likely to be a vexing one. It might end up more of a binding legal contract than consent as we understand it now. Xenotransplantation is also unlikely to cost less than, or significantly alleviate the shortage of, cadaveric organs in the short term. The international dimension of the risk of infection is becoming obvious, but there has so far been no effort to convene an international forum to agree on universally acceptable guidelines.

45 of 52

TI: Methodological issues in the use of biological markers in cancer epidemiology: cohort studies.
AU: Hunter-DJ
AD: Harvard School of Public Health, Department of Epidemiology, Boston, MA 02115, USA.
SO: IARC-Sci-Publ. 1997(142): 39-46
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: In this chapter we summarize the major strengths and weaknesses of cohort studies; consider how these characteristics influence the use of biomarkers in cohort studies; briefly review considerations of statistical power, design and the influence of measurement error in cohort studies; and discuss some of the emerging ethical considerations that relate to the use of biomarkers in prospective studies.

46 of 52

TI: Synergy, antagonism, and scientific process [editorial]
AU: Hook-GE; Lucier-GW
SO: Environ-Health-Perspect. 1997 Aug; 105(8): 784
this source is not Available in S.J.M.C.Library
LA: ENGLISH

47 of 52

TI: Human rights, ethics and the Krever inquiry [editorial]
AU: Hoey-J
SO: CMAJ. 1997 Nov 1; 157(9): 1231
this source is not Available in S.J.M.C.Library
LA: ENGLISH

48 of 52

TI: Notifying patients exposed to blood products associated with Creutzfeldt-Jakob disease: integrating science, legal duties and ethical mandates [see comments]
AU: Caulfield-T; Dossetor-J; Boshkov-L; Hannon-J; Sawyer-D; Robertson-G
AD: Health Law Institute, Faculty of Law, University of Alberta, Edmonton.
SO: CMAJ. 1997 Nov 15; 157(10): 1389-92
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The issue of notifying people who have been exposed to blood products that have been associated with Creutzfeldt-Jakob disease (CJD) has arisen at a time when the Canadian blood system is under intense scrutiny. As a result, the Canadian Red Cross Society issued a recommendation to health care institutions that recipients of CJD-associated blood products be identified, notified and counselled. Although Canadian jurisprudence in the realm of informed consent may support a policy of individual notification, a review of the scientific evidence and the applicable ethical principles arguably favours a policy of a more general public notification. Indeed, situations such as this require a unique approach to the formation of legal and ethical duties, one that

effectively integrates all relevant factors. As such, the authors argue that individual notification is currently not justified. Nevertheless, if a system of general notification is implemented (e.g., through a series of public health announcements), it should provide, for people who wish to know, the opportunity to find out whether they were given CJD-associated products.

49 of 52

TI: Equal treatment: bestowed or earned? [comment]
AU: Soskolne-CL
AD: Department of Public Health Sciences, University of Alberta, Edmonton, Canada.
SO: Ann-Epidemiol. 1997 Oct; 7(7): 434-6
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: PURPOSE: While the complaint against non-industry employed epidemiologists for holding their industry-based colleagues to a higher level of scrutiny is accurate, this paper shows that there is a sound basis for such treatment. It also shows, however, that a shift towards ongoing vigilance is needed on the part of all epidemiologists to guard against such bias. METHODS: The proposed shift is made possible through the recent incorporation in ethics guidelines of principles that indeed identify the impropriety of any such bias. RESULTS: In the same guidelines, there are principles that require scientific impartiality. Industry-based epidemiologists, by the condition of their employment, may find the avoidance of partiality to the corporate interest more problematic than do non-industry based epidemiologists to their respective sponsors. It is in light of past examples of partiality among industry-based epidemiologists that other epidemiologists may be biased against them. CONCLUSIONS: This paper concludes with the realization that both groups of epidemiologists have the challenge of correcting the biases inculcated over many years. Trust needs to be established between industry and non-industry-based epidemiologists through greater acceptance on the part of the latter and exemplary conduct on the part of the former to overcome past practice records.

50 of 52

TI: Unintended consequences and professional ethics: criminalization of alcohol and tobacco use by youth and young adults.
AU: Wolfson-M; Hourigan-M
AD: Division of Epidemiology, School of Public Health, University of Minnesota, Minneapolis 55454, USA.
SO: Addiction. 1997 Sep; 92(9): 1159-64
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This paper describes how widespread legal changes appear to have affected law enforcement practices concerning youth tobacco and alcohol use in the United States. We argue that the threat of criminalization was seldom addressed in scientific and public policy discussions of the drinking age, and only sporadically addressed in discussions of measures to regulate youth access to tobacco. We argue that unintended consequences are an important ethical issue for professionals involved in advocating, developing, implementing and evaluating public policy concerning substance abuse.

51 of 52

TI: Confidentiality, disseminated regulation and ethico-legal liabilities in research with hidden populations of illicit drug users.
AU: Fitzgerald-JL; Hamilton-M
AD: Department of Public Health and Community Medicine, University of Melbourne, Parkville, Victoria, Australia. johnfitz@ariel.ucs.unimelb.edu.au
SO: Addiction. 1997 Sep; 92(9): 1099-107
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: An assurance of confidentiality is at the core of trusting relationships in

outreach, ethnographic research and patient/client encounters. In the past, centralized State health care services have provided assurances of confidentiality to those engaged in health-related research either through common law or by statute. However, unless specific confidentiality legislation is in place, no assurances of confidentiality can now be made to research subjects involved in either longitudinal, interview-based or ethnographic research. The consequences of this situation become more serious given the recent emergence of the use of peer and community outreach. A significant problem with the outreach model is the failure to provide adequate legal and ethical support for those in outreach roles. Additionally, unless research subjects can be granted assurances of confidentiality, they will not engage in research for fear of later prosecution. At this time when outreach models are the modus operandi, the lack of a fundamental commitment to sustain confidentiality may seriously undermine further research. This paper will draw on the experiences of some Australian qualitative research and will review some of the ethical and legal liabilities for research that arise when an assurance of confidentiality cannot be given to those participating in research.

52 of 52

TI: Legal history of emergency medicine from medieval common law to the AIDS epidemic.
AU: Curran-WJ
AD: Department of Health Policy and Management, School of <u>Public</u> <u>Health</u>, Harvard University, Boston, MA, USA.
SO: Am-J-Emerg-Med. 1997 Nov; 15(7): 658-70
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The early development of legal obligation in emergency medicine is traced through medieval English common law to the first stages of American law after Independence. An identifiable set of legal principles in the nineteenth and early twentieth centuries is described. The movement away from an absence of legal and ethical duties to answer any emergencies, or to offer any emergency services in hospitals, toward a growing demand for access to emergency services in the middle decades of the twentieth century is reviewed. The enactment of Good Samaritan Laws is described, along with other federal and state law reforms. In the modern era, there has been a substantial legal and ethical change to a requirement of extensive duties to operate open-admission emergency services in virtually all acute-care hospitals. The AIDS epidemic is utilized as a case example of expanded legal and ethical duties to offer emergency care in a nondiscriminatory manner to all patients presenting at hospital emergency departments.

1 of 14

TI: [Public health work is improvement without impairment]
AU: Wall-S; Weinehall-L
AD: Institutionen for epidemiologi och folkhalsovetenskap, Umea universitet.
SO: Lakartidningen. 1998 Sep 2; 95(36): 3807-8, 3811
this source is not Available in S.J.M.C.Library
LA: SWEDISH; NON-ENGLISH
AB: Strategies for community intervention, their evaluation and social patterning are discussed in the article. Theories and methods are called for to enable better assessment of social inequalities in health outcome variables and processes in public health endeavours. With this is a starting point some methodological and ethical issues relating to preventive programmes and their evaluation are identified.

2 of 14

TI: Develop and strengthen public health law.
AU: L'hirondel-A; Yach-D
AD: Policy Action Coordination Team, World Health Organization, Geneva.
SO: World-Health-Stat-Q. 1998; 51(1): 79-87
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The rule of law consists of one of the key requirements to implement policy reforms. The new global health policy, "Health for All in the 21st Century", indicates the role of public health law to attain its values and objectives. This article studies the status retained to secure both international and national law in the new policy, and identifies two initiatives to be undertaken by WHO to develop and strengthen public health law. The usefulness and efficiency of international law depend on national capacities to implement law. Thus, this article concludes that the Organization should adopt international legal instruments and that it should, simultaneously, assist Member States to build institutional and human capacity in public health law. However, these initiatives require that all Member States confirm political determination to link economic and social reforms with legislative reforms.

3 of 14

TI: Health for all: analyzing health status and determinants.
AU: Lerer-LB; Lopez-AD; Kjellstrom-T; Yach-D
AD: Programme on Substance Abuse, World Health Organization, Geneva.
SO: World-Health-Stat-Q. 1998; 51(1): 7-20
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: An analysis of health status and determinants is presented as a basis for health for all renewal and in order to provide a model linking the health for all vision with strategy and action. Equity and gender, at the core of health for all, directly concern health status and the distribution of health determinants. The role of the various transitions (demographic, epidemiological, health risk and technological) is described, the need to strengthen the link between data and decision-making for health is explained, and the range of health determinants--macroeconomic, demographic/nutritional, environmental, tobacco and alcohol and their implications for policy--is outlined.

4 of 14

TI: The beast inside.
AU: Klotzko-AJ
AD: Institute of Medical Ethics, Edinburgh.
SO: Nurs-Times. 1998 Aug 5-11; 94(31): 34-5
this source is not Available in S.J.M.C.Library
LA: ENGLISH

5 of 14

TI: Physicians as double agents: maintaining trust in an era of multiple accountabilities.
AU: Shortell-SM; Waters-TM; Clarke-KW; Budetti-PP
AD: School of Public Health, Division of Health Policy and Management, University of California, Berkeley 94720-7360, USA.
shortell@uclink4.berkeley.edu
SO: JAMA. 1998 Sep 23-30; 280(12): 1102-8
This source is Available in S.J.M.C Library
Call Number: From: 1918+
LA: ENGLISH

6 of 14

TI: Health reform in America: the mystery of the missing moral momentum.
AU: Brown-LD
AD: Division of Health Policy and Management, Columbia School of Public Health, New York City, USA.
SO: Camb-Q-Healthc-Ethics. 1998 Summer; 7(3): 239-46
this source is not Available in S.J.M.C.Library
LA: ENGLISH

7 of 14

TI: Presentation: Epidemiology and public health: is a new paradigm needed or a new ethic? [see comments]
AU: Gori-GB
AD: The Health Policy Center, Bethesda, Maryland 20816-1016, USA.
SO: J-Clin-Epidemiol. 1998 Aug; 51(8): 637-41
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1994+
LA: ENGLISH
AB: Public health militancy has been increasingly frustrated by what many perceive as the marginally fertile studies of risk factors operating at the individual level, whose causal underpinnings are often and inevitably weakened in multifactorial situations. As a remedy, leading advocates propose a refocusing of epidemiology and public health on socioeconomic, cultural, and political studies, and on broad interventions at population level. This new "paradigm" would be aided by a relaxation of evidentiary standards of causality, away from scientific criteria and more toward dialectic (rhetorical) precepts derived in a humanistic and sociologic tradition. It is countered here that such proposals would further reduce the objectivity and thus likely weaken rather than strengthen epidemiology and the justification of public health action. Instead, a realistic appraisal finds that multifactorial epidemiology raises warning signals of varying influence, and that the usefulness of epidemiology and public health could be enhanced by conceiving of methods to score the relative strength and priority of such warnings.

8 of 14

TI: American Association of Public Health Dentistry. Code of ethics and standards of professional conduct.
SO: J-Public-Health-Dent. 1998; 58 Suppl 1: 123-4
this source is not Available in S.J.M.C.Library
LA: ENGLISH

9 of 14

TI: Dental public health competencies.
SO: J-Public-Health-Dent. 1998; 58 Suppl 1: 121-2
this source is not Available in S.J.M.C.Library
LA: ENGLISH

10 of 14

TI: Preamble to the competency statements for dental public health.
SO: J-Public-Health-Dent. 1998; 58 Suppl 1: 119-20
this source is not Available in S.J.M.C.Library
LA: ENGLISH

11 of 14

TI: HIV testing of infants: privacy and public health.
AU: Etzioni-A
AD: George Washington University, USA.
SO: Health-Aff-Millwood. 1998 Jul-Aug; 17(4): 170-83
this source is not Available in S.J.M.C.Library
LA: ENGLISH

12 of 14

TI: [Basic medical competence: a neglected educational goal in medical education?]
AU: Perleth-M
AD: Abteilung Epidemiologie und Sozialmedizin, Medizinische Hochschule Hannover. perleth@epi.mh-hannover.de
SO: Med-Klin. 1998 Jun 15; 93(6): 381-7
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH
AB: This paper analyses some recent proposals of how to change undergraduate medical education in Germany and in other countries. This leads to the formulation of a set of fundamental clinical competencies, which are defined as skills that enable physicians to react to challenges pertaining to their work in a professional way. These fundamental clinical competencies comprise knowledge, skills and attitudes. With regard to the actual performance of the German system of undergraduate medical education, deficits are depicted in the following areas: psychosocial and communicative competencies including advice and provision of information to patients, primary care, public health, ethics and clinical epidemiology/evidence-based medicine. For each of these areas, a proposal for change is provided.

13 of 14

TI: Balancing the quality of consent.
AU: Hansson-MO
AD: Department of Public Health and Caring Sciences, Academic Hospital, Uppsala, Sweden.
SO: J-Med-Ethics. 1998 Jun; 24(3): 182-7
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The rule that one must obtain informed consent is well established in medical ethics and an intrinsic part of clinical practice and of research in biomedicine. However, there is a tendency that the rule today is being applied too rigidly and with too little sensitivity to the values that are at stake in connection with different kinds of research protocols. It is here argued that the quality of consent needs to be balanced against variables such as degree of confidentiality and importance of values at stake, in order to be ethically acceptable. Appropriate information and consent procedures should be adjusted accordingly. Three levels are suggested, ranging from extensively informed consent with both written and oral information, through informed refusal with only a limited amount of information given to, at the other end of the scale, just making relevant information available.

TI: [Evolution of medical responsibility and code of <u>ethics</u>]
AU: Glorion-B
AD: Conseil national de l'Ordre des Medecins, Paris.
SO: Bull-Acad-Natl-Med. 1998; 182(3): 553-8
<u>this source is not Available in S.J.M.C.Library</u>
LA: FRENCH; NON-ENGLISH

AB: The evolution of the medical responsibility cannot escape from the determining influence of the scientific progress, but it is also significantly influenced by sociological and psychological factors that often are more difficult to analyse. If the ethical rules express the physicians' obligations in legal terms, it perfectly determines the spirit which must drive every physician thus revealing his sense of responsibility. This concept of the medical responsibility distinguishes and differentiates itself from the penalty responsibility and from the compensation responsibility which only takes place in the context of the compensation for a harm caused. The acquisition of the prime sense of the responsibility is a product of a background dominated by the experience, the example, the conscience. The expression of the medical responsibility is most of all personal, but more and more fits in with the <u>public health</u> issues and becomes a collective responsibility. Finally in order to meet the more and more accurate specialists' demands, the physician's responsibility which must remain within the boundaries of his competence must be fulfilled in the frame of a team. This dimension imposes on him new regulations that affect the quality of the relationship between the various contributors. An evolution of the responsibility thus grows according to the progress and within the adapted scope of <u>ethics</u>.

Enclosure (10a)

Ethics in Medical Education

Dr. C. M. Francis

Dr. C. M. Francis, formerly with St. John's Medical College, is Consultant to Community Health Cell, Bangalore.

> ***"Education is not for knowing more but for behaving differently"***
> ***– Ruskin***

Medical ethics is a neglected subject. Medical educators had been paying insufficient attention to developing the student's capability to face ethical dilemmas. But, in recent times, many medical schools abroad have instituted courses in medical ethics.

Many of the ills of the present day medical profession can be traced to the lack of doctors' ability to properly tackle ethical problems in their practices. Practically nothing is being done to equip the medical students to practice ethically.

Most medical colleges do not have medical ethics in their curriculum. Even in the very few (they can be counted on the fingers) which have, the teaching/learning of medical ethics is not a 'required' subject.

What do doctors (after graduation) think about the need for training in medical ethics? 90% of the respondents to a survey wanted training in medical ethics during undergraduate medical education. 84.5% admitted that they did not have any training at all.

Ethics depends on the values of the profession and society. Among the important values in medicine are respect for human life and love and compassion. Charaka Samhita (6th century B.C.) states:

"He who practices, not for money or for caprice but out of compassion for living beings is the best among all physicians. Hard is it to find a conferor of religious blessings comparable to the physician who snaps the snares of death for his patients. The physician who regards compassion for living beings, as the highest religion, fulfills his mission and obtains the highest happiness".

Learning Medical Ethics

Thompson in an editorial in the '*Medical Education* has pleaded for the integration of medical ethics in medical education. The World Health Organisation (WHO) and the Council for International Organisation of Medical Science and others have emphasised the same need.

Can ethics be 'taught' or is it 'caught'? It is important that 'ethics' is learned. The principles and practice of medical ethics can be learned in a variety of ways and situations: in the classrooms, during bedside-teaching and ward-rounds besides from the examples set by by the faculty and the institution. A role model is very important. The teacher shows how the ethical principles are applied to a particular patient. The student is helped to identify the ethical problems, with respect to the patient, the family and the community.

The way the institution functions can have a marked impact on the student. If the institution as a whole, acts responsibly, gives respect to the patients (and others) and observes the ethical code of conduct in providing service, training or research, the student would imbibe these values. Thus the philosophy and practice of the medical college play an important role in shaping an ethically sound doctor. The objectives must be clear. They must be reinforced by ethical actions at every level; management, administration, faculty and other staff.

A Pro-patient Approach

> We tend to consider patients as 'teaching material': in fact, they are technical teachers.

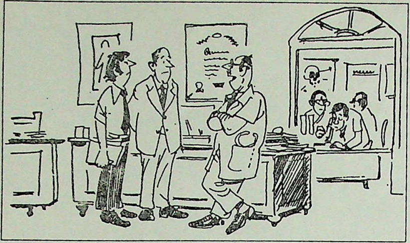
If we realise this fact, we will give greater respect to our patients. It is unfortunate that there is no 'home visiting' in the training of medical students. It is getting out of fashion! We want the patients, whatever be their condition, to come to the clinic or hospital. Home visiting could have added to the values.

Ethics in Selection of Students

What determines the quality of a doctor? It is very difficult to alter the personality traits of a student when he/she enters the medical college at the age of say, of 17 or 18. If positive traits and qualities are present, it is easier to nurture and strengthen them.

There are a few medical colleges which take the process of selection very seriously, like St. John's Medical College, Bangalore and Christian Medical College, Vellore. In St. John's, the process consists of an entrance test; in which one paper is on values, a 2-day group observation, a psychological test and the usual short interview.

Most of the medical colleges (especially the Government Medical Colleges) go by the academic grades at the common entrance test. A cadre of students who are intellectually narrow cannot be expected to be-



Of course, the capitation fee for our medical course includes charges for a passport, visa and emigration formalities...

Courtesy: R.K. Laxman

come sensible doctors. Worse still is the situation of 'capitation fee' colleges. **When admission is decided by money power, one cannot expect the medical graduates to cultivate the desired ethical values.**

Principles of Medical Ethics

The major principles of medical ethics are:

Beneficence

All medical interventions must be for the good of the patient (and family and society).

Non-maleficence

Cause no harm. Where harm might occur, it must be minimal and the benefit must outweigh the harm.

Autonomy

Traditionally, we had accepted the *ethics of trust*. But in recent times, due to western influence, it is giving way to the *ethics of rights*. Patient has the right to control what happens to him or her.

Informed Consent

Patients' consent is necessary for all procedures. The consent has to be informed and voluntary. The information must be complete and adequate for the patient to make a considered decision.

Justice

There is need for distributive justice. There is also a need to allocate resources fairly and evenly. Equity has to be assured and this has to be done with quality.

Community Health

While it is important to think of the individual patient, there is a need to consider the diagnosis and management of community's illnesses and health problems. Thus, there is interdependability of society and medicine.

Clinical Ethics

The practice of medicine, with respect to the patient-doctor relationship, has certain goals:

- Preservation of life (prolongation of life).
- Cure of the disease.
- Relief of suffering (and symptoms).
- Care of the person.
- Promotion of health and prevention of disease.
- Restoration of function and rehabilitation.

To make a ethical decision in a clinical situation, at least four factors must be considered:

a. ***Medical Indication***

Make a proper diagnosis. Consider alternative therapeutic modalities. Weigh their relative advantages and disadvantages, short-term and long-term. Inform the patient of the available options, recommend the best.

b. ***Patient Preference***

The patient accepts or rejects the recommended procedure. The decision of the patient must be respected. If the doctor feels that a particular procedure is essential in an emergency, the doctor must try to convince the patient of its essential nature.

c. ***Quality of Life***

It is important to consider the quality of life after the procedure which may be subjective. It has to be determined by the concerned person and not by a third person.

d. ***Allied Factors***

Questions of benefit or burden to other parties (family, relatives) needs consideration. Of late, the cost of medical care has risen exorbitantly. Medical care can ruin families, even when the benefit to the patient is marginal or doubtful.

Ethical Issues Before the Profession

1. Negligence

The doctor-patient relationship is in the nature of an implied contract. The doctor has a duty of care in

- deciding whether to accept the patient for treatment;
- deciding in diagnosis and management; and
- administering the treatment.

If there is breach of duty, the doctor is negligent. If harm is caused to the person, damages can be awarded against the doctor. *"In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical man at that time".*

A negligent doctor could be sued in a court of law or disciplinary action taken against him/her by the Medical Council. Under the Consumer Protection Act, 1986, the consumer courts can order compensation to the complainant *"who hires any services for a consideration which has been paid or* *promised... and includes beneficiary of such services..."*

"The physician who sets about to treat a disease, without knowing anything about it, is to be punished even if he is a qualified physician; if he does not give proper treatment, he is to be punished more severely; and if by his treatment, the vital functions of the patient are impaired, he must be punished most severely".

2. *Confidentiality*

Every patient has a right to privacy. Matters confined to the doctor in the course of professional relationship is confidential. This is upheld in all oaths and declarations (Hippocratic oath; Geneva declaration etc.). Confidentiality has to be observed with respect to medical records also.

Information may be given to a third party only under the following circumstances:

- Notifiable diseases (to the health authority).
- Risk to public safety (under defined circumstances).
- Disclosure ordered by the court or required by law.

3. *Irrational Drug Therapy*

Drugs must be used for proper indications. They must be effective, have good benefit - risk ratio and should be of good quality. Banned, hazardous and useless drugs should not be used.

4. *Prescriptions*

Irrational prescriptions can occur in a variety of ways, such as extravagant, unnecessarily and expensive, incorrect and multiple (too many drugs prescribed, often in combinations). -

5. *Patients' Bill of Rights (abridged)*

A patient has the right to:

- considerate and respectful care.
- obtain from his physician complete information concerning diagnosis, treatment and prognosis.
- refuse treatment to the extent permitted by law.
- every consideration for confidentiality and privacy.
- refuse participation in any research or projects.
- expect reasonable continuity of care.
- examine and receive explanation of his bill.
- know the hospital rules applying to his/her conduct as a patient.
- access to medical records

6. *Abortion*

The Medical Termination of Pregnancy Act, 1971 permits ending of pregnancy for therapeutic, eugenic and personal considerations. Most of the codes of conduct and declarations are opposed to it.

"I will maintain the utmost respect for human life, from the time of conception" (World Medical Association, Geneva, 1948). -

7. *Female Foeticide and Infanticide*

Society, in general, is pro-male. Prenatal sex determination is done most often with the intention of rejecting the female foetus. Though this is banned, selective female foeticide continues.

8. *Assisted Reproductive Technologies*

There is a biological, cultural and social urge to have children. What should the doctor do when there is infertility? Disturbed function must be treated. Often no particular cause can be found.

> One answer to not having own children is adoption. But it is not popular in India, though very popular in western countries, where there are not enough children for adoption.

There are many new technologies of reproduction such as artificial insemination by husband or by a donor; in-vitro fertilisation and embryo transfer, gamete intra-fallopian transfer and surrogacy. Each one brings in its own ethical problems.

9. *The Terminally Ill*

The doctor has to face the problem of managing the terminally ill and the dying. It is very important to deal with them with competence and compassion. Many of them have symptoms such as intense pain and respiratory distress. Relief of these symptoms is important. Relief of pain may produce ethical issues, when large amounts of potent analgesics may have to be administered, these may have side effects of depressing respiration. But if the primary aim is relief of pain and there was no intention of shortening life, the procedure is ethically acceptable.

Often heroic efforts are made to preserve or prolong life. But, when there is no reasonable hope of any benefit to the patient, there is no need to resort to extraordinary measures to preserve life. It may not be prolonging life but prolonging death.

More and more doctors tend to decide not to resuscitate patients admitted to the intensive care units, when death is the most likely outcome to avoid suffering and wastage of resources.

10. *Living Will*

The living will gives the preference of the person at the time of making it. It does not give the wish at the time when the patient is seriously ill. It is not legal in India.

There is considerable controversy on the issue of euthanasia, whether passive or active. Both of them raise ethical issues.

11. *Suicide*

When a person fails to find meaning in his or her life or has muddled it (often financial problems), he/she may attempt suicide. It often arises from despair, which may be temporary. Attempted suicide is punishable in law. Attempt at suicide is often a call for help.

12. *Technology*

There is a sudden spurt in the growth of costly medical technology, whether diagnostic or therapeutic. Expensive and complicated techniques are introduced without properly conducting controlled trials.

"It is surely a great criticism of our profession that we have not organised a critical summary...of all the relevant randomized controlled trials".

John Kenneth Galbraith (the noted Economist and former US Ambassador to India), has said that large corporations often say that they meet the needs and demands of the people. But what they really do is to create a demand for what they want to supply. Public desires are manipulated. A similar thing often happens with newer medical technologies - equipment, procedures or drugs.

Many ethical questions arise when doctors use technologies which are not beneficial to the patient or when better and less costly technologies exist.

13. *Health Policy*

Doctors often shy away from health policies, leaving them to administrators, bureaucrats and politicians. This is totally wrong. Health policy defines the strategies for the health of the people. It depends on the value systems and therefore raises many ethical questions.

Health policy should ensure a minimum acceptable level of health care forall. It should lead to equity with quality. While a purely medical response is inadequate, the medical professionals, individually and collectively, must address the issues of health care. The doctors will have to make ethical choices and advise the people and the policy makers on required improvements.

14. *Distributive Justice*

Large sections of our people live in deplorable conditions where healthy living is not possible. About 200 millions are destitutes. This is negation of health. Health care in an unjust society is unjust.

15. *Human Experimentation and Research*

The various codes of conduct have stated the conditions under which human experimentation and research can be carried out ethically. It is important to have an Ethics Committee or Ethical Review Board, whose clearance must be obtained for the project. These can be constituted with representatives of the medical teachers (other than the researchers), research consultant (preferably a social scientist), ethics consultant and a legal consultant. If desired, the Medical and Nursing Superintendents and the Spiritual Advisor or Counsellor could also be included.

16. *Emerging Diseases*

The medical students must get the capability to deal with emerging disease or the newer manifestations of older diseases. The student must 'learn to learn'. One such disease with many ethical issues is AIDS. Many of the earlier graduates have not seen such cases. They are unable to comprehend the seriousness of HIV infection and the ethical problems arising from them. Continuing education, including ways to tackle the ethical issues, is a must.

17. *Genetics*

With the study of the human genome and genetic engineering, a list of ethical issues arise. We do not know how to tackle them.

> *"The world that we have made as a result of the level of thinking that we have done so far, creates problems we cannot solve at the level we created them".*
>
> *– Albert Einstein*

Note: A curriculum covering the above mentioned issues in medical ethics is being followed at St. John's Medical College, Bangalore. The duration is 15 hours in pre-clinical years and 15 hours in clinical years. The faculty consists of clinicians who are ethically literate and practicing; ethicists; sociologists etc. The judicious mingling of faculty trained in different disciplines brings in different view points which stimulates the moral reasoning and ethical judgement in medical students and practicing doctors. ■

A code of ethics

THE major source of information about drugs is the pharmaceutical industry, and much of that information takes the form of promotion. Controlling excessive and misleading promotion of drugs is therefore a key measure in improving their rational use. Clinical pharmacologist Dr. Andrew Herxheimer, coordinator of the International Society of Drug Bulletins which links nearly 50 bulletins worldwide that provide independent and comparative information on drugs, describes drug promotion as "the truth, the half-truth and nothing like the truth."

The industry spends about twice [illegible] much on promoting its products as it does on research. Canadian physician Dr. Joel Lexchin says that, in developing countries at least, promotional expenditure is 20-30 per cent of sales (*Pharmaceutical Promotion in the Third World*).

Since 1981 the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) has had a voluntary code of practice to cover marketing and promotion. Most national industry associations have similar voluntary codes. Herxheimer, who conducted a survey on the effectiveness of the voluntary code in the United Kingdom, describes these codes as "much more show than substance. Codes are interpreted rather literally. The spirit of the code is usually disregarded. Enforcement doesn't exist. There are no sanctions. The same companies repeat their transgressions again [illegible]d again."

The latest study to document this problem has been carried out by the Office of Technology Assessment (OTA) of the United States Congress. It found the label and package inserts for at least half of a sample of 241 products sold by U.S.-based companies in four countries — Brazil, Kenya, Panama and Thailand — failed to provide sufficient information for doctors to use the drugs safely and effectively. The report concluded that relying on information from manufacturers could lead to "serious or life-threatening medical problems or, at best, ineffective treatment" (*Drug Labelling in Developing Countries*.)

In 1988, the WHO published its Ethical Criteria for Medicinal Drug Promotion to provide general principles which governments could adapt to their national situation. However, as Dr. Joe Collier, editor of *Drug and Therapeutics Bulletin*, and Robin Fox, editor of *The Lancet*, said in an article in (*The Lancet*, April, 1993), "these clear and straightforward criteria have been much neglected."

The following are the key elements of the WHO's ethical criteria:

★ Promotion should be reliable, accurate, truthful, informative, balanced, up-to-date, capable of substantiation and in good taste. It should not contain misleading or unverifiable statements or omissions likely to induce medically-unjustifiable drug use or to give rise to undue risks.

★ The word "safe" should only be used if properly qualified.

★ Promotional material should not be designed so as to disguise its real nature.

★ Financial or material benefits should not be offered to or sought by health care practitioners to influence them to prescribe drugs.

★ Scientific and educational activities should not be deliberately used for promotional purposes.

★ Drug advertisements should not be directed at children.

★ Advertisements should usually contain, among others, the name(s) of the active ingredient(s) using either international non-proprietary names or the approved generic name of the drug; the brand name; the dosage form or regimen; the content of active ingredient(s) for each dosage form or regimen; the name of other ingredients known to cause problems; approved therapeutic uses; side effects and major adverse drug reactions; precautions, contra-indications and warnings; major interactions; the name and address of the manufacturer or the distributor.

★ Prescribers and dispensers should be provided with complete and unbiased information for each product.

★ The main part of the remuneration of medical representatives should not be directly related to the volume of sales they generate

★ Post-marketing scientific studies and surveillance should not be misused as a disguised form of promotion. ■

Courtesy: Panos Briefing

HAROON HABIB
in Dhaka

THE first major task Lt. Gen. Hossain Mohammad Ershad, now facing jail term on charges of corruption and misuse of power, took upon himself as Bangladesh's President was to implement a revolutionary programme — the National Drug Policy (NDP). Introduced in 1982, soon after he captured power in a coup, the policy banned 1,666 "useless, ineffective or harmful drugs" and selected 250 essential medicines for the country. While many at home and abroad welcomed it as most forward-looking, a section of multinationals and the country's drug manufacturers criticised it as too radical and grossly arbitrary.

Ershad relentlessly enforced the policy during the nine years of his rule. He clamped strict controls to keep the prices of drugs within the purchasing capacity of the people and stopped the production of drugs under third party licence. Framed in the light of the World Health Organisation's (WHO) concept of essential drugs, the policy was acclaimed all over the world. More than a hundred countries followed the Bangladesh model.

But the policy is now at a crossroads. Certain influential Ministers of the Begum Khaleda Zia Government believe it has opened the market to spurious medicines. Particularly critical of it is Finance Minister M. Saifur Rahman who favours its scrapping on the plea that all controls on the pharmaceutical industry should go, when the country is pursuing the free-market mechanism.

According to Saifur Rahman, the policy destroyed the only blue chip industry of the country. "The shortsightedness of some egomaniacs is responsible for this debacle," he says. But Health and Family Welfare Minister, Chowdhury Kamal Ibne Yusuf is not in full agreement. He feels the policy needed to be reviewed and the opinion of leaders of the industry had to be taken into account.

Salman F. Rahman, a leading industrialist, says the policy was nothing more than guidelines for drug registration. "Even its positive aspects were undermined as it was implemented without discussion with all concerned. The policy thus lost its credibility."

The process of scrapping the policy started in 1992 following the assumption of office of the elected government of Prime Minister Khaleda Zia. With

From: SHUBHA@cedban.ilban.ernet.in
Organization: CED, BAngalore
To: sochara@blr.vsnl.net.in
Date: Sat, 27 Jun 1998 17:52:20 +5.30
Subject: Welcome to il-nuke
Priority: normal

Dear Thelma,

Thanks for everything!

Pl. see the message below and substitute il-med-ethics for il-nuke. more later. If you need anymore help pl. write back.
shubha
------- Forwarded Message Follows -------

SJ|AC
Can you get on to the Med. Ethics Mailing list + print out material as it comes.
C/R c Shubha for any prob.
Jw
4/11/98.
File in Med. Ethics Resource File

Date sent: Tue, 23 Jun 1998 13:47:26 +0530
To: cedban.ilban.ernet.in!shubha
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3. Subsequent to the Pokhran Nuclear Tests by India the debate on nuclear issues has begun in dead earnest and many individuals and organisations have felt the need to

(217)
20/6/98

express their viewpoint widely and forcefully. If you have something to say on this topic here is an opportunity.

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With regards,

Aspi B. Mistry
IndiaLink
Mumbai.

UNESCO

REPRODUCTIVE HUMAN CLONING : ETHICAL ISSUES

CM
23/2/99

June 1998

I. BACKGROUND

In 1993, Federico Mayor, Director-General of UNESCO, created the International Bioethics Committee (IBC), which is interdisciplinary and multicultural in nature. The IBC is the only body within the United Nations system to carry out bioethical reflection on research in biology and genetics and their applications, and is a unique forum for debate and for the elaboration by UNESCO of standard-setting instruments in this area.

Indeed, the IBC was entrusted by the Director-General to draw up an international instrument on the human genome. In December 1996, after four years of intensive work, the Legal Commission of the IBC approved a revised preliminary draft, which was finalized in July 1997 by a Committee of Governmental Experts. The **Universal Declaration on the Human Genome and Human Rights** was adopted by the 29th Session of the General Conference of UNESCO, on 11 November 1997.

On 24 February 1997, the Director-General of UNESCO expressed his position on the debate unleashed by the successful cloning of an adult sheep, ruling out the application of this technology to humans. On 28 February, Federico Mayor issued the following statement:

> "The cloning of an adult sheep using DNA from an udder - successfully accomplished by a team of scientists from the experimental farm of the Roslin Institute of Edinburgh, (UK) - represents a decisive technological step forward for biology. From a scientific standpoint cloning was already practised at other levels of animal experimentation.
>
> Bovine embryos have been commonly cloned for several years, notably in view of selecting the most profitable cross-breeds, but this event opens new perspectives. But it also raises many questions and fears regarding the possible application of this technology to humans. We must safeguard human kind's infinite diversity, our biological and cultural unicity.
>
> I applaud this scientific and technological achievement which will have a considerable impact on biology, especially on embryology and genetics. It will help alleviate and even prevent human suffering. Nevertheless, beyond scientific knowledge and technological possibility, ethics must draw the divide between the possible and the acceptable."

Consequently, he requested the International Bioethics Committee to inform him of the extent to which the future declaration on the human genome rules out human cloning and any use of this technology which might undermine the dignity and identity of each human being.

II. THE INTERNATIONAL DEBATE

All members of the IBC were consulted by correspondence on this issue. On 14 May 1997, a meeting was convened at UNESCO on "Animal Biotechnology, Cloning and Transgenic Technology". The participants stressed the necessary distinctions between human reproductive cloning aimed at the birth of an individual and non-reproductive human cloning techniques for research, diagnostic or therapeutic purposes. Since these latter techniques do not aim at the reproduction of an individual, only the former was examined from an ethical perspective.

A consensus emerged that reproductive cloning of human beings should not be permitted. Besides safety considerations, three main ethical arguments were voiced. Reproductive cloning:

- undermines genetic indeterminability (by intervening on the "genetic lottery");
- overrates the biological/genetic link (although some participants felt that the arguments against reproductive cloning fell precisely into the trap of this overrated biological/genetic link);
- could instrumentalize human beings, thus reducing them to the level of tools, and consequently would be contrary to human dignity.

A number of countries had already adopted legislation covering this issue and, since February 1997, several national bioethics committees or other bodies have expressed their views.

This issue was also raised at the "Denver Summit of the Eight" in June 1997 and the final communiqué states:

> "*Human Cloning*
> 47. We agree on the need for appropriate domestic measures and close international cooperation to prohibit the use of somatic cell nuclear transfer to create a child."

More recently, the VIIth Latin American Summit of Heads of State and Government on "Democracy and Ethics", which was held in Isla Margarita (Venezuela) in November 1997, in supporting UNESCO's Universal Declaration on the Human Genome and Human Rights, affirmed its opposition to the utilization of practices contrary to human dignity, such as reproductive cloning of human beings.

Likewise, several intergovernmental organizations, such as the Council of Europe(1) (Additional Protocol to the Convention on Human Rights and Biomedicine of the Council of Europe of 12 January 1998), the European Parliament(2) (Resolution on Cloning of 12 March 1997), the European Union - particularly through its Group of Advisers on the Ethical Implications of Biotechnology(3) (Opinion N°9 of 28 May 1997 on 'Ethical Aspects of Cloning Techniques') - and the World Health Organization (see below) have taken a similar stand on this subject.

It should be noted that the World Health Assembly, at its 50th Session on 14 May 1997, adopted a resolution affirming that:

> "The use of cloning for the replication of human individuals is ethically unacceptable and contrary to human integrity and morality."

A subsequent meeting on "Human cloning - The global response" was organized by the World Health Organization, on 24 October 1997. Its aim was to review the different positions - legal, cultural and religious - concerning the possible application of cloning techniques to the human being in view of a report on this subject for the 51st Session of the World Health Assembly in May 1998.

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(1) Information can be obtained from: Council of Europe, B.P. 6341 R6 - 67075 STRASBOURG Cedex, France.

(2) Information can be obtained from: European Parliament, avenue de l'Europe, B.P. 1024 - 67070 Strasbourg Cedex, France.

(3) Information can be obtained from: European Commission, Rue de la Loi 200 - 1049 Brussels, Belgium.

More recently, a draft resolution on "Ethical, scientific and social implications of cloning in human health" - which makes specific reference to UNESCO's Universal Declaration on the Human Genome and Human Rights -, adopted by the 101st Session of the Executive Board of WHO, will be presented to the 51st Session of the World Health Assembly in May 1998. It states in particular that:

> "... cloning by means of somatic cell nuclear transfer for the replication of human individuals is both ethically and biomedically unacceptable and contrary to human dignity and integrity."

As for international non-governmental organizations, the World Medical Association, by a Resolution of May 1997, "calls on ... researchers to abstain voluntarily from participating in the cloning of human beings". A Recommendation adopted by the International Federation of Gynecology and Obstetrics (FIGO) in July 1997 states that "cloning to produce a human individual ... is unacceptable".

Religious authorities have also taken a stand on this issue: to mention just a few, the Church of Scotland, the Holy See, a group of Muslim theologians.

A report on "Cloning animals and humans", presented to the 1997 General Assembly of the Church of Scotland, said:

> "The Church of Scotland has already stated that to clone human beings would be ethically unacceptable as a matter of principle. On principle, to replicate any human technologically is a violation of the basic dignity and uniqueness of each human being ... It is not the same as twinning. There is a world of difference ethically between choosing to clone from a known existing individual and the unpredictable occurrence of twins of unknown nature in the womb. The nature of cloning is that of an instrumental use of both the clone and the one cloned as means to an end, for someone else's benefit. This represents unacceptable human abuse, and a potential for exploitation which should be outlawed worldwide."

In a document entitled "Reflections on Cloning", published in July 1997, the Pontifical Academy for Life stated:

> "Human cloning belongs to the eugenics project and is thus subject to all the ethical and juridical observations that have amply condemned it. ... At the level of human rights, the possibility of human cloning represents a violation of the two fundamental principles on which all human rights are based: the principle of equality among human beings and the principle of non-discrimination."

During a meeting on 14-17 June 1997 in Casablanca, Morocco - organized jointly by the Islamic Organization for Medical Sciences, the WHO Regional Office for the Eastern Mediterranean, the Islamic Educational, Scientific and Cultural Organization and the Fiqh Academy of the Organization of Islamic Conference - more than 60 doctors of Islamic law expressed their total opposition to human cloning. This ban also aims to prevent developing countries from becoming a laboratory for possible experimentation in this field. In particular, it states that:

> "Ordinary human cloning, in which the nucleus of a living somatic cell from an individual is placed into the cytoplasm of an egg devoid of its nucleus, is not to be permitted."

III. REPRODUCTIVE CLONING AND THE UNIVERSAL DECLARATION

At its 29th Session, on 11 November 1997, the General Conference of UNESCO adopted, unanimously and by acclamation, the **Universal Declaration on the Human Genome and Human Rights**, the first universal instrument in the field of biology. The General Conference matched the Universal Declaration with a resolution on its implementation, which commits States to taking appropriate measures to promote the principles set out in the Declaration.

The Declaration, which aims above all to protect human rights from possible infringements arising from research on the human genome and their applications, specifically mentions the issue under consideration in its Section C, entitled "Research on the Human Genome".

In this section, Article 10 contains one of the cornerstones of the Declaration when it affirms the primacy of respect for human rights over research in biology, genetics and medicine. It is inadmissible for such research and research applications to pursue goals which are contrary to human rights, fundamental freedoms and the dignity of both individuals and groups of individuals, in particular certain populations or minorities, or for the manner in which they are conducted to be at variance with human rights, fundamental freedoms and human dignity.

As a result of the primacy of respect for human rights, Article 11 states that:

> "Practices which are contrary to human dignity, such as reproductive cloning of human beings, shall not be permitted."

Article 11 further draws attention to the responsibility of States and competent international organizations in that respect and to the need for co-operation among them. It should be noted that in this sense the Universal Declaration concurs with paragraph 11 of the Declaration of the World Conference on Human Rights of 25 June 1993, which, with regard to advancement in biomedical and the life sciences, explicitly calls upon States to co-operate in order "to ensure that human rights and dignity are fully respected".

IV. CONCLUSION

The Universal Declaration on the Human Genome and Human Rights is a landmark instrument - the first in the field of genetics within the United Nations system. One of the issue it addresses is that of human cloning, which - with the adoption of this Declaration - the international community has now identified as a practice "contrary to human dignity".

What exactly does this text set out to do and why is UNESCO promoting the promulgation of guidelines that seek to prohibit the application of a revolutionary scientific development?

The answer to this question is that UNESCO is committed to ensuring that, like all other forms of knowledge, science effectively serves the cause of human progress and that the Declaration is concerned with making science accord with ethics in the new Promethean age we are now entering.

The Universal Declaration on the Human Genome and Human Rights begins by affirming the fundamental unity of all the members of the human family beyond their genetic diversity. Individuals can never be reduced to their genetic material. Because of their freedom of judgement and of choice, human beings transcend their genetic condition. This means that science is not the arbitrator of what constitutes human value or a valuable human life.

It is vital to stress this fundamental principle which cannot accommodate the reproductive cloning of human beings - a technique which denies the uniqueness which is our birthright. That uniqueness is at the heart of our identity; it is the core of our existence. Its value is absolute and cannot be relinquished.

Although it does not have binding force, this Declaration represents a moral commitment of all Member States of UNESCO to adhere to a coherent set of ethical principles in the field of genetics. It is now for these Member States, in co-operation with the scientific community, to translate the principles set out in the Declaration into national legislation and regulations - a process already under way in a number of countries, particularly in Eastern Europe.

At the turn of the century, solutions to the most acute world problems require a strong science and technology component. At the same time, these problems have an essential ethical dimension. This is why UNESCO gives the highest priority to its ethical mandate. This is why it tries to reconcile scientific freedom and the defence of human rights in the field of human genetics - a field that presents us with challenges and opportunities in equal measure.

LEGISLATION/VIEWS ON HUMAN CLONING AT NATIONAL LEVEL[*]

ARGENTINA	By a decree of 7 March 1997, the President of Argentina declared that all cloning experiments in connection with human beings should be prohibited and requested the Ministry of Health and Social Action to prepare a draft bill in this respect. The draft bill, dated 17 April 1997, states in its Article 1 that 'experiments concerning cloning of human cells in order to generate human beings are hereby prohibited'.
BULGARIA	On 3 April 1997, the Bulgarian Academy of Sciences, the Bulgarian National Academy of Medicine and the National Agricultural Academy organized a Conference on Human Cloning. The Conference pointed out that the scientific research in this field should be pursued under strict conformance with adequate requirements (biological, medical, social, psychological, legal), reflected in widely accepted legal norms.
CANADA	The Bill C-47 (First reading, 14 June 1996), respecting human reproductive technologies and commercial transactions relating to human reproduction - cited also as the Human Reproductive and Genetic Technologies Act - states that 'no person shall knowingly ... manipulate an ovum, zygote or embryo for the purpose of producing a zygote or embryo that contains the same genetic information as a living or deceased human being or a zygote, embryo or foetus, or implant in a woman a zygote or embryo so produced'.
CHILE	In a Declaration on human cloning of 22 April 1997, the Commission of Ethics, Culture and History of the Faculty of Medicine of the University of Chile, in referring explicitly to the Universal Declaration on the Human Genome and Human Rights drawn up by UNESCO, expressed its opposition to all biomedical research concerning human cloning, even with a medical purpose.
CHINA	In May 1997, the Chinese Academy of Sciences banned research on human cloning.
DENMARK	Under Act 503 on a Scientific Ethical Committee System and the Handling of Biomedical Research Projects of 1992, research on cloning (production of genetically identical individuals) is forbidden. Act 460 on Medically Assisted Procreation of 1997 complements this position by affirming that treatment may not be initiated in areas where a research ban already exists under the 1992 Act.
FRANCE	At the request of President Chirac, the Consultative National Ethics Committee for Health and Life Sciences (CCNE), in its Opinion N° 54 of 22 April 1997, deemed necessary to oppose by all possible means the development of practices leading to the identical reproduction of a human being and to research which might lead to this end, recourse to cloning being a serious infringement on the dignity of the human person.
GERMANY	Under the Federal Embryo Protection Act of 1990, the creation of an embryo genetically identical to another embryo, foetus or any living or dead person is an offence.
INDIA	In December 1997, the Indian Council of Medical Research issued a Consultative Document on Ethical Guidelines on Biomedical Research Involving Human Subjects. The section dealing with genetics states that cloning through nuclear transplantation 'definitely should be forbidden by law'.
ITALY	By a decree of 5 March 1997, the Minister of Health prohibited all form of experimentation and intervention aiming, even indirectly, at human or animal cloning. For its part, on 21 March 1997, the National Bioethics Committee (CNB) expressed its opposition to human cloning, considered as an infringement on the uniqueness of each human being and of his or her dignity.

(*) Document compiled by the Bioethics Unit of UNESCO.

JAPAN	In May 1997, the Ministry of Health and Welfare and the Ministry of Education, Science, Culture and Sports set up advisory committees to discuss the issue of human cloning. In January 1998, the Council for Science and Technology, chaired by the Prime Minister, set up another committee on cloning, expected to report by May 1998 on the appropriateness of introducing legislation to ban reproductive human cloning
NEW ZEALAND	The Human Assisted Reproductive Technology Act, which came into force on 1 January 1997, establishes a legal framework for restrictions and controls on assisted reproductive technology and creates a Human Assisted Reproductive Technology Authority. Cloning is one of the forbidden activities which cannot, under any circumstance, be authorized.
NORWAY	Law 56 of 1994 on the medical use of biotechnology implicitly prohibits embryo cloning.
PORTUGAL	On 1st April 1997, the National Council of Ethics for the Life Sciences states that 'the cloning of human beings, because of the problems it raises concerning the human dignity, the equilibrium of the human species and life in society, is ethically unacceptable and must be prohibited'.
RUSSIAN FEDERATION	On 12 January 1998, the Russian Institute of Molecular Genetics Research called for a law banning human cloning.
SLOVAKIA	The Health Care Law of 1994 implicitly prohibits embryo cloning.
SPAIN	Law 35/1988 concerning medically assisted reproduction, in Chapter VI, Article 20, deems that the creation of identical human beings by cloning, or any other technology for race selection purposes, is a serious infringement on human rights, with criminal sanctions.
SWEDEN	Law 115 of March 1991 implicitly prohibits embryo and ovocyte cloning with criminal sanctions.
SWITZERLAND	The Federal Constitution implicitly prohibits embryo cloning (amendment of 13 August 1982). If adopted, the Federal Bill on Medically Assisted Procreation of 1997 will explicitly prohibit embryo and ovocyte cloning with criminal sanctions.
TUNISIA	At the request of the Minister of Health, the National Medical Ethics Committee examined the issue of cloning. Following initial discussions, the Technical Section of the Committee concluded that any technology of human cloning should be banned. It deems this technology to be an infringement on all references in the field of human reproduction and on the dignity of the human species and an open door to all drifts.
UNITED KINGDOM	In the United Kingdom a ban on human cloning had been proposed in 1984 in the Warnock Report, the basic Committee of Enquiry into Human Fertilisation and Embryology. Following that recommendation, the Human Fertilisation and Embryology Act of 1990 provided for just such a ban on human cloning. Research involving the use of human embryos is strictly controlled under the terms of this Act, which would require a licence to be issued by the Human Fertilisation and Embryology Authority. In May 1997, the Human Genetics Advisory Commission (HGAC) decided to explore ways of holding a public consultation exercise on the implications of developments in cloning. More recently, in January 1998, a consultation document, entitled 'Cloning Issues in Reproduction, Science and Medicine' was published by the HGAC and the Human Fertilisation and Embryology Authority (HFEA). In addition, the Royal Society issued, in January 1998, a statement on cloning. In this statement, entitled 'Whither cloning?', the Council of the Royal Society 'with respect to human cloning, supports the view that reproductive cloning of humans to term by nuclear substitution is morally and ethically unacceptable and believe it should be prohibited'.
UNITED STATES OF AMERICA	On 24 February 1997, President Clinton requested the National Bioethics Advisory Commission to examine the legal and ethical issues associated with the use of the new cloning technology. The Commission, in its Report of June 1997, concluded that 'at this time it is morally unacceptable for anyone in the public or private sector, whether in a research or clinical setting, to attempt to create a child using somatic cell nuclear transfer cloning'. On 9 June 1997, President Clinton proposed to the Congress a Cloning Prohibition Act of 1997. In January 1998, the American Society for Reproductive Medicine (ASRM) presented a draft bill banning over a certain period the cloning of living or dead human beings.

WORKSHOP ON ETHICS IN CLINICAL RESEARCH IN DEVELOPING COUNTRIES.

Ethics in Overseas-funded Research in Developing Countries.

T Jacob John, Vellore, India.

Summary

A wider discussion among non-tradional-ethicists on the validity, applicability and above all the consistent use (or problems thereof) of the widely acclaimed basic principles of ethics in clinical practice and research is timely and essential. This personal viewpoint paper presents some of the less recognised issues covering the spectrum of first principles to day-to-day activities.

The main issues include a tension between ethics as we understand and cultural values in some regions of the world, and arising partly from it a very much stunted health care, public health and research efforts, the conceptualisation of autonomy, the difficulties in realising informed (truly) consent (truly voluntary), and the vulnerability and injustice suffered by people of poor backgrounds when seeking health care in the scientific medical system. We need orders of magnitude more of research to solve innumerable problems and we need to apply time tested basic principles of public health, if we take justice and nonmalficence seriously. If there is a feeling that ethics apply only to acts of commission, we must examine the failure of ethical understanding of the gross and grotesque attitude of non-action.

Background.

As the world is going through rapid changes, and as most if not all transactions are at least in part driven by profit motive, the tendency or opportunity for exploitation of the less informed or the less powerful is becoming almost universal. Therefore, in order to ensure that transactions remain fair and just to the participating subjects in clinical research and to service recipients in clinical practice, strict adherence to ethical principles are essential everywhere.

Whenever a system, be it health care, clinical research, public health or social support, is brought into play to cope with the problems of people with HIV or acquired immune deficiency syndrome (AIDS), its deficiencies become apparent. Recently, issues about the ethics of clinical research in developing countries have received much attention due to a debate on clinical trials to reduce perinatal transmission of human immunodeficiency virus (HIV) (1). I quote from a recent editorial: "The ethics of American researchers or funders conducting research in resource-poor environment is challenging beyond words. In the examples at hand, we face an agonizing choice. On the one hand, by adhering to western standards of medical care we could produce great benefit to the persons who participate in trials but slower progress for medical science. On the other hand, by providing less benefit to research participants in developing countries than that which is provided in developed countries, we are more likely to yield quicker and more relevant answers for the larger community. Such a dilemma calls for extensive further public discussion, which must include the voices of all relevant communities, from American researchers, funders and IRDs (institutional review boards) to local country researchers, governments, review boards and most essentially potential research participants and their communities. We can be confident that the ethics of international research will benefit from so much public attention" (2). (Read 'overseas' for 'American'). Our discussions here are certainly relevant and timely.

To
TN/VB/CMF
for information. He
had written to us for
our views and we had
also suggested a dialogue
with him on the issue. See his
note overleaf (last page)

RN
18/1/99

The main issues.

In all that I have understood, 'everyone' (mostly western colleagues and a handful of compatriots with whom these issues have been discussed) accepts that the current stated principles of ethics in medical research, namely autonomy, beneficence, nonmalficence and justice are universally true and valid. The absolute need for informed consent by participants derives directly from the principle of autonomy. Its fundamental basis is the supremacy of the individual, a concept which itself has its roots in the so-called western culture, deriving from the Judeo-Christian understanding of humans in relationships. While I do not personally question its validity, I do question whether this basis, and its derivations have been rubbed against the touchstones of other philosophies or belief systems of oriental, Asian, African and native peoples of the New World. I do recall a recent incident in which an English youngster was given corporal punishment in Singapore for an act of vandalism and the consternation it created in the west. That illustrated the differences in the relative value given in some cultures to the individual versus the group. I have often wondered but not investigated if the basic assumptions of fundamental individual rights, upon which modern medical ethics are founded, will always be in accordance with the *Sharia* laws. I have a suspicion that many professionals in poor countries may consider that strict adherence to ethics in medicine is not possible due to ideological and practical reasons. The necessary process of crosschecking the validity of the basics of medical ethics is perhaps not appropriate for us to undertake, but we might make a point here that a broader dialogue with other points of view may be essential if we are to address them in medical research (and much more importantly in clinical practice) in developing countries with diverse social, cultural, religious and economic backgrounds. At the very least, such a dialogue will be essential for us to ensure that the basic ethical principles (perceived to be 'western' in origin) will be accepted and applied in diverse environments. .

Modern medicine (clinical practice and clinical research) itself is a product of the so-called western culture. Those who practice it are necessarily educated in its basics (in science and objectivity, and its need to question and experiment on any and every tenet), even though they themselves may have different belief systems that do not fully accommodate these elements. I personally believe that there is tension between the two belief systems in many societies, which is not properly examined, articulated or reconciled, and to that extent, modern medicine remains alien to many a local culture; if not alien, at least not fully integrated with, or absorbed within, the local culture. (I also attribute this unrecognised difficulty as one of the causes of the unsatisfactory health care systems in many developing countries, and not merely a lack of funds. If cost was the main impediment to health care, we should have seen the growth of primary health care up to the limits of affordability, which is not the case in many societies, particularly India). The medical personnel learn to accept the tension by compartmentalisation, so that it does not impair performance. The human subjects of research, on the other hand, may not understand the very nature of research, nor live by the belief system out of which the ethical tenets have arisen. We may believe in the value of always speaking the truth. There may be people who believe that in communications truth is less important than what is pleasant or appropriate. We may believe that all are equal. There may be people who do not believe so. We believe in direct cause and effect. There may be people who do not believe in cause and effect, but may attribute events to divine decisions or actions or to immutable (except by the divine) destiny (such as fatalism). Even in the western (and other) Christian circles, and in other religions as well, some felt HIV/AIDS to be God's punishment on sinners and felt justified to abandon those whom 'God had condemned' (3). We believe that truth is verifiable; others may believe that truth is what you believe and verification is superfluous. We may accept questioning widely, but others may consider it inappropriate and disrespectful of what is respected and sacred. As a successful medical researcher in India, I am struck by the extreme paucity of research by peers, aimed at solving the local and glaring problems in health care and public health, and also by the extreme neglect of even the very basic primary health care and public health by successive elected governments. The explanation is more likely the cultural belief system and not an inhuman callousness.

It is in the concept of autonomy, perhaps, that there may be the biggest problem with universal applicability, if not validity. To be autonomous, one has to be convinced of the supremacy of the individual. In many societies, decisions are often made by the elders for the younger ones, or by the chief for the group or by parents for their offspring. For people brought up in such traditions, autonomy as we with western (mostly Christian) education or background understand, may be alien to their thought processes. Therefore, patients everywhere, but more obviously in developing country backgrounds tend to "relinquish autonomy to professional authority, in the expectation of competence" (4). In such situations, informed consent, given voluntarily, is difficult, if not virtually impossible, to obtain.

Many developing countries are in the process of eradication of poliomyelitis. This entails virtually every child being given multiple doses of oral polio vaccine. A small number of children will develop paralysis due to the vaccine itself (calculated to be about 50 per year in India alone). It is called vaccine associated polio. Beneficence and nonmalficence, as well as justice, will demand that such children who develop this severe adverse reaction directly due to participation in a global programme, not voluntarily, but by government directive, must be treated free of charge and also compensated adequately. Certainly in India and probably in many other developing countries as well, such children, as also others with wild virus induced poliomyelitis (as a result of the error of policy regarding the number of doses of vaccine to be taken, or in other words defective service), are left to fend for themselves, with the government accepting no responsibility whatsoever for their treatment and rehabilitation. Such a situation is virtually untenable in a western society, but in India, there is no sensitivity to the ethical norms of a medical intervention for the benefit of the many (indeed for the entire world), but the adverse reaction of which is suffered by the few. What is interesting, the programme is heavily funded by several developed countries (if India continues to have polioviruses, the world cannot eradicate). Moreover, the WHO is directly involved in the reporting and investigation of children with polio so that its experts know which children have vaccine associated polio and which have wild virus induced polio due to defective service. The public and the health care staff who report the children with paralysis are not given (nor do they want) this information. I depict these to emphasise the lack of ethical urgency or even sensitivity; people (including most professionals) and the government accept theses with a sense of fatalism.

The clinical trials to define methods of prevention of perinatal HIV transmission raised several questions in ethics. The ACTG 076 study gave HIV infected pregnant women zidovudine orally from the second trimester and intravenously during labour. The neonates were given syrup zidovudine for 6 weeks. These interventions reduced the frequency of HIV transmission in nonbreast-fed babies by about 66% (from 25 % to 8%) (5). This treatment has now become the standard treatment in the USA (6). The total drug doses have been costed at over 800 US dollars which is about twice the per capita annual income of people in several countries (7). Since then at least 16 randomised clinical trials have been approved for conduct in Africa, Asia and the Caribbean (8). Most of them are placebo controlled. Some are to investigate shorter courses of zidovudine, and others use other interventions such as vitamin A or HIV immunoglobulin (8). The acute debate and division are on the ethics of using a placebo arm in these studies (1,7,9,10). Since the ACTG

076 has become standard treatment in the USA, one argument is that any further studies, especially if funded by a developed country source, must be controlled with the standard treatment; placebo control is therefore unethical (9,10). On the opposite side, there is cogent argument to support the need for placebo controlled trials to find less expensive regimens to reduce perinatal transmission (11). For one thing, ACTG 076 is not implementable in developing countries. Even if one arm had ACTG 076 as control (equivalency study), the study will be inconclusive since we can assume that the arm with any shorter course of treatment would have a higher frequency of transmission than the control. So then, it would be virtually impossible to assess the reduction in transmission that the short course would have caused without simultaneously measuring what the risk of the study group was for such transmission without intervention (11).

Discussion

In many if not most developing countries, sick people do not get a fair deal unless they purchase health care. Scientific medicine is very expensive. (Therefore, alternate systems remain popular, which is a positive outcome of an otherwise unhealthy situation). Research to find new solutions to even urgent or rampant problems is conspicuous by its infrequency. The so-called tropical diseases are prevalent, not because of tropical climate, but because even the elementary principles of public health are not applied (12). The general belief is that the root cause of this situation is poverty. I contest that. True, poverty reduces options, but does not remove the option of elementary preventive public health. Poverty is an alibi the rich nations attribute and the not-so-rich countries readily accept and perpetrate, by which they do not have to face the real reasons which are in the realm of 'culture' or the world view of humans in relationships with themselves, with others and with God (and/or Nature). The 'culture' of the west, with all its tremendous contributions, has (perhaps) gone wrong in understanding the true nature of humans within Nature, whereas many other cultures have all along been more correct. I suspect that it has also gone too far in pushing the ideal of individual advancement (indulgence, supremacy) even at the expense of group interests. This is a form of 'paganisation', a deviation from the Judeo-Christian view of humans in relationships. (Am I my brother's keeper?). In the culture in which I live, salvation (nirvana) is a personal proposition between you and your god, it is no one else's business, nor are you responsible for anyone else's.

To me this imbalance between the individual's rights and group interests became an acute problem, facing HIV/AIDS among ordinary people in India, but now within the newly transplanted mindset of people that it was a gay plague, or a prostitute's problem, or God's punishment on wrong-doers, an instant killer, a hopeless malady and so on. Modern mass media had brought all these well before we saw the very first 'case' (another pejorative term?). My personal guilt is that I introduced HIV testing in India, long before AIDS was recognised, but even doctors confused one for the other. Now they had a tool to detect and reject those with HIV and even today this tragic drama continues unabated. Strong ethical views made a difference in the west, but the milieu for meaningful ethical confrontation does not exist in India. Gross injustice is being thrust upon people with HIV/AIDS. The problem is by and large neglected, not due to inhuman callousness, but due to a different understanding of humans in relationships.

So, what can we conclude? As human rights issues have been internationalised, medical ethics also needs visibility and wider discussion.

If researcher and subject as well as clinician and client transactions must be brought within the ambit of ethics, we must help nations to internalise the basic principles.

The subject or client is from a different cultural background than the assumed culture of the researcher/care giver, while playing that role. Perhaps autonomy needs redefinition. Perhaps the first in the list of principles must be justice (which may be more easy to understand across cultures) rather than autonomy. Perhaps, clinical practice must become based on solid ethics before we can address ethics in research. Perhaps, the absence of research is a more serious ethical problem than previously recognised.

External funding has been presented as a potential constraint in ethical conduct of research, as it brings to focus the gross disparities in what is standard care versus what is locally the norm. External funding is indeed a good thing from ethics point of view because it demands attention on ethics. To bring in hidden motives in research, the institutional review boards (they must, obviously exist) must identify all the cast and crew, on stage and backstage, not merely the subject, researcher and funder. If an industry will benefit from research, that (not at all a bad thing) must be clearly identified, so that unseen forces can be made visible. The board must also identify the intended emotive and substantive benefits of the researcher in order to help them themselves understand ethical issues more clearly. Since the clinical setting makes it virtually impossible to make the transactions 'equal', and true autonomy is virtually absent in most situations, informed consent must be taken more seriously than as a ritual; but justice and nonmalficence must be the first points to teach and learn. Perfect research need not be the enemy of good and essential research.

References.

1. Bayer R. The debate over maternal-fetal HIV transmission prevention trials in Africa, Asia and the Caribbean: Racist exploitation or exploitation of racism? Amer J Public Health 1998; 88: 567-570.
2. Faden R, Kass N. Editorial: HIV research, ethics and the developing world. Amer J Public Health 1998; 88: 548-550.
3. John TJ. Sexuality, sin and disease: theological and ethical issues posed by AIDS to the churches. The Ecumenical Review, 1995; 47: 373-
4. Sigeriat HE (1960) The special position of the sick; Parsons T (1951) The social system; Kirby MD (1983) Informed consent. What does it mean? Cited by: Karim QA, Karim SSA, Coovadia HM, Susser M. Informed consent for HIV testing in a South African hospital. Is it truly informed and truly voluntary? Amer J Public Health 1998; 88: 637-640.
5. Connor EM, Sperling RS, Gelber R et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. New Engl J Med. 1994; 331: 1173-1180.
6. US Public Health Task Force on the use of zidovudine to reduce perinatal transmission of human immunodeficiency virus. Morb Mortal Wkly Rep. 1994; 43: 1-20.
7. Varmus H, Satcher D. Ethical complexities of conducting research in developing countries. New Engl J Med 1997; 337: 1003-1005.
8. Annas GJ, Grodin MA. Human rights and maternal-fetal HIV transmission prevention trials in Africa. Amer j Public Health 1998; 88: 560-563.
9. Lurie P, Wolfe SM. Unethical trials of interventions to reduce perinatal transmission of human immunodeficiency virus in developing countries. New Engl J Med 1997; 337: 853-856.
10. Angell M. The ethics of clinical research in the third world. New Engl J Med. 1997; 337; 847-849.
11. Karim SSA. Placebo controls in HIV perinatal transmission trials: A South African's viewpoint. Amer J Public Health 1998; 88: 564-566.
12. John TJ. An Indian point of view (On Tropical Diseases) Lancet 1997; 349: SIII, 31-32.

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orders in the operating room, published by the American Society of Anesthesiologists and the American College of Surgeons are used to provide a perioperative DNR order management approach consistent with the Joint Statement on Resuscitative Interventions. PRINCIPAL FINDINGS AND CONCLUSIONS: The dominant principle is that of the patient's right to self determination. This right can be exercised either directly by the patient, or through an appropriate alternate, or in the form of an advance directive. DNR orders are not incompatible with subsequent surgical care in an operating room. It is wrong to suspend automatically DNR orders in the perioperative period. It is wrong to continue DNR orders automatically in the perioperative period. It is wrong to make assumptions about the meaning of an individual DNR order. An appropriate approach to the perioperative management of pre-existing DNR orders is one based on "required reconsideration." All anaesthetists must be aware of their responsibilities in managing patients with DNR orders in place.
MESH: Ethics,-Medical; Patient-Advocacy
MESH: *Operating-Rooms; *Resuscitation-
TG: Human
PT: JOURNAL-ARTICLE
AN: 96437273
UD: 9702

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Marked in Search: #5

✓ TI: Recommended guidelines for reviewing, reporting, and conducting research on in-hospital resuscitation: the in-hospital "Utstein style". American Heart Association.
AU: Cummins-RO; Chamberlain-D; Hazinski-MF; Nadkarni-V; Kloeck-W; Kramer-E; Becker-L; Robertson-C; Koster-R; Zaritsky-A; Bossaert-L; Ornato-JP; Callanan-V; Allen-M; Steen-P; Connolly-B; Sanders-A; Idris-A; Cobbe-S
AD: Emergency Cardiac Care Committee, American Heart Association, Dallas, Tx 75231-4596, USA. docroc@u.washington.edu
SO: Ann-Emerg-Med. 1997 May; 29(5): 650-79
This source is Available only few issues in S.J.M.C. Library
ISSN: 0196-0644
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Decision-Trees; Ethics,-Medical; Life-Support-Care; Medical-Records-standards; Outcome-and-Process-Assessment-Health-Care; Resuscitation-methods; Resuscitation-standards; Resuscitation-Orders
MESH: *Hospitals-; *Inpatients-; *Resuscitation-
TG: Human
PT: GUIDELINE; JOURNAL-ARTICLE; PRACTICE-GUIDELINE; REVIEW; REVIEW,-TUTORIAL
AN: 97284979
UD: 9707
SB: AIM

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Marked in Search: #5

TI: Research with cognitively impaired subjects. Unfinished business in the regulation of human research [see comments]
CM: Comment in: Arch Gen Psychiatry 1997 Feb;54(2):117-20. Comment in: Arch Gen Psychiatry 1997 Feb;54(2):121-3
AU: Bonnie-RJ
AD: Institute of Law, Psychiatry, and Public Policy, University of Virginia, Charlottesville, USA.
SO: Arch-Gen-Psychiatry. 1997 Feb; 54(2): 105-11
This source is Available in S.J.M.C Library
Call Number: From: 1959+
ISSN: 0003-990X

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PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: In 1978, the National Commission for the Protection of Human Subjects of
Biomedical and Behavioral Research issued an important report that addressed
the difficult ethical issues arising in research involving subjects with mental
disabilities. However, because of irreconcilable conflicts between the
scientific community and rights-oriented advocacy groups, the federal
government never issued the special regulations pertaining to these issues that
had been envisioned by the National Commission. Because these important ethical
issues have not yet been adequately addressed by policy-making bodies,
protection of cognitively impaired subjects depends too heavily on the diverse
ethical sensitivities of individual investigators and on ad hoc responses of
particular institutional review boards. Researchers should support a credible
and authoritative process for reexamining and resolving ethical issues relating
to research with cognitively impaired subjects. This can be accomplished
without leading to the stalemate that doomed the National Commission's
proposals. The challenge is to forge a consensus on ethical guidelines and
safeguards that will most reasonably accommodate the goals of protecting the
dignity and well-being of research subjects while avoiding undue impediments to
valuable scientific inquiry.
MESH: Human-Experimentation; Informed-Consent; Mental-Disorders-psychology;
Patient-Advocacy; Research-Design-standards; United-States
MESH: *Ethics,-Medical; *Mental-Competency; *Mental-Disorders
TG: Human; Support,-Non-U.S.-Gov't
PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
AN: 97192684
UD: 9705
SB: AIM

                                                                 23 of 27
                                                      Marked in Search: #7
TI: [Ethical guidelines for scientific research in human individuals supported
by FAPESP. Bioethics Group and Population Research]
TO: Diretrizes eticas para pesquisas em grupos humanos financiadas pela FAPESP.
Grupo de Bioetica e Pesquisa Populacional.
SO: Rev-Assoc-Med-Bras. 1996 Jul-Sep; 42(3): 167-8
    this source is not Available in S.J.M.C.Library
ISSN: 0104-4230
PY: 1996
LA: PORTUGUESE; NON-ENGLISH
CP: BRAZIL
AB: Ethical guidelines were developed for research projects involving human
groups in biomedical and human sciences areas. The text is divided into four
parts: premises, principles, procedures and recommendations. The granting
agency will institute an Ethical Review Board to mediate ethical conflicts
identified in the research project. It is intended for the guidelines to be
reviewed in 3 to 4 years.
MESH: English-Abstract; Research-Support
MESH: *Ethics,-Medical; *Guidelines-; *Human-Experimentation;
*Research-standards
TG: Human; Support,-Non-U.S.-Gov't
PT: JOURNAL-ARTICLE
AN: 97284284
UD: 9709

                                                                 24 of 27
                                                      Marked in Search: #7
TI: Medical and scientific uses of human tissue [editorial]
AU: O'Neill-O
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SO: J-Med-Ethics. 1996 Feb; 22(1): 5-7
    <u>this source is not Available in S.J.M.C.Library</u>
ISSN: 0306-6800
PY: 1996
LA: ENGLISH
CP: ENGLAND
AB: Inevitably a policy-oriented report on issues as complex and as rapidly changing as the medical and scientific uses of human tissue can achieve neither philosophical purity nor regulatory completeness. The council's strategy has been to begin with robust ethical principles, for which sound philosophical arguments can be given, which will (it is hoped) command widespread support. The council went on to argue for <u>guidelines</u> of sufficient, but not vapid, generality which could be of practical use to the various medical intermediaries, professional and regulatory bodies and <u>research</u> <u>ethics</u> committees which will carry out the tasks of detailed regulation and of making decisions that affect uses of human tissue. The council's hope is that the recommendations of the report can be absorbed into regulatory and professional practice, and where needed into government policy. If they can, the increasing diversity of uses of human tissues need lead neither to overt nor to covert 'commercialisation of the human body', but will also not put unnecessary restrictions on advances in <u>research</u> and medical practice.
MESH: Biological-Specimen-Banks-economics;
Biological-Specimen-Banks-legislation-and-jurisprudence; Cadaver-;
Great-Britain; Tissue-Culture; Tissue-Donors
MESH: *Biological-Specimen-Banks; *<u>Ethics,-Medical</u>; *Human-Rights
TG: Human
PT: EDITORIAL
AN: 97086524
UD: 9705

25 of 27
Marked in Search: #7

TI: Ethical issues in genetic <u>research</u>: disclosure and informed consent.
AU: Reilly-PR; Boshar-MF; Holtzman-SH
AD: Shriver Center for Mental Retardation, Waltham, Massachusetts 02154, USA.
SO: Nat-Genet. 1997 Jan; 15(1): 16-20
    <u>this source is not Available in S.J.M.C.Library</u>
ISSN: 1061-4036
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: As <u>research</u> to correlate genetic status with predisposition to disease has accelerated, so has the concern that participation in such studies creates the risk of genetic discrimination and emotional distress. There is a need to broaden disclosure during the consent process to ensure that potential subjects understand these risks and other issues and to address them in the consent form. We describe the broad approach that we have taken in regard to disclosure and consent in gene mapping studies.
MESH: Adult-; Child-; Chromosome-Mapping; Genetics,-Medical-legislation-and-jurisprudence; <u>Guidelines-</u>; Prejudice-; <u>Research-legislation-and-jurisprudence</u>; United-States
MESH: *<u>Ethics,-Medical</u>; *Genetics,-Medical; *Informed-Consent; *<u>Research-</u>;
*Truth-Disclosure
TG: Human
PT: JOURNAL-ARTICLE
AN: 97141913
UD: 9704

26 of 27
Marked in Search: #7

TI: The Helsinki Declaration, research guidelines and regulations: present and future editorial aspects [editorial]
AU: Dale-O; Salo-M
SO: Acta-Anaesthesiol-Scand. 1996 Aug; 40(7): 771-2
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1971-1978 & 1985
ISSN: 0001-5172
PY: 1996
LA: ENGLISH
CP: DENMARK
MESH: Guidelines-
MESH: *Ethics,-Medical; *Human-Experimentation
TG: Human
PT: JOURNAL-ARTICLE
AN: 97028547
UD: 9703

27 of 27
Marked in Search: #7

TI: Ethical clinical practice of functional brain imaging. Society of Nuclear Medicine Brain Imaging Council.
SO: J-Nucl-Med. 1996 Jul; 37(7): 1256-9
this source is not Available in S.J.M.C.Library
ISSN: 0161-5505
PY: 1996
LA: ENGLISH
CP: UNITED-STATES
AB: The development and evolution of functional brain imaging technology and their broad application to a wide range of neurological and psychiatric disorders have led to their scientifically sound use in specific clinical situations. In addition, there is a growing diversity of empirical new applications where there is little previous research or clinical experience. Therefore, a committee of the Brain Imaging Council of the Society of Nuclear Medicine was formed to address the need for specific guidelines regarding scan interpretation and reporting. This committee considered the wide range of current and potential uses of PET and SPECT, including its growing role in forensics. A set of basic guidelines for the reporting and interpretation of brain imaging studies applicable to all clinical situations, including forensics, was formulated. These guidelines were composed in a manner sensitive to the need for standards that are scientifically defensible now, and which will continue to be valid as the field evolves. It is the intent of the committee and its summary document to positively influence the clinical use of brain SPECT and PET by offering guidance concerning the elements essential to a complete and useful clinical report, defining standards to differentiate well-established clinical applications from research uses and providing a framework in which to consider the appropriateness of functional brain imaging used in the forensic arena.
MESH: Nuclear-Medicine-legislation-and-jurisprudence; Societies,-Medical
MESH: *Brain-radionuclide-imaging; *Ethics,-Medical; *Tomography,-Emission-Computed; *Tomography,-Emission-Computed,-Single-Photon
TG: Human
PT: GUIDELINE; JOURNAL-ARTICLE; PRACTICE-GUIDELINE
AN: 96268163
UD: 9702

1 of 9
Marked in Search: #9

TI: Ethics in environmental epidemiology.
AU: Rossignol-AM
AD: Department of Public Health, Oregon State University, Corvallis 97330-6406, USA.
SO: Epidemiology. 1997 Sep; 8(5): 599-601
this source is not Available in S.J.M.C.Library
ISSN: 1044-3983
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Research-
MESH: *Environmental-Health; *Epidemiology-; *Ethics,-Medical; *Practice-Guidelines
TG: Human
PT: MEETING-REPORT
AN: 97417017
UD: 9712

2 of 9
Marked in Search: #9

TI: Guidelines for managing domestic abuse when male and female partners are patients of the same physician. The Delphi Panel and the Consulting Group.
AU: Ferris-LE; Norton-PG; Dunn-EV; Gort-EH; Degani-N
AD: Department of Public Health Sciences, Faculty of Medicine, University of Toronto, Ontario, Canada.
SO: JAMA. 1997 Sep 10; 278(10): 851-7
This source is Available in S.J.M.C Library
Call Number: From: 1918+
ISSN: 0098-7484
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: OBJECTIVE: To provide clinical guidelines for primary care physicians who are dealing with domestic abuse and who have both the abused woman and her partner as patients. PARTICIPANTS: A 15-member expert panel with members having experience in family practice, gynecology, emergency medicine, medical ethics, nursing, psychology, law, and social work; an 11-member consulting group with members representing medicine, consumers, police, psychology, social work, and nursing; and participants from focus groups including 48 previously abused women and 10 previously abusive men. Members of the expert panel and the consulting group were recruited by the research team. Focus group members were recruited through the agencies from which they were receiving services. EVIDENCE: Available research information, and opinions of the expert panel, the consulting group, and the focus group participants. CONSENSUS PROCESS: Scoring of 144 clinical scenarios was performed by the expert panel using a modified Delphi technique involving 4 iterations. Scenarios were rated in terms of best practice for primary care physicians dealing with suspected and confirmed cases of physical abuse. Consulting group members and focus group participants then commented on the panel's results. Final guidelines were approved by the panel and the consulting group, with comments reserved in the guidelines for

information from focus group participants. CONCLUSIONS: It is not a conflict of interest for the physician to deal with abuse of the female partner when both partners are patients. Both patients have a right to autonomy, confidentiality, honesty, and quality care. Patients should be dealt with independently, thereby facilitating assessment of the magnitude and severity of the victim's injuries. Physicians should not discuss the possibility of domestic abuse with the male partner without the prior consent of the abused female partner. Joint counseling is generally inadvisable and should be attempted only when the violence has ended, provided both partners give independent consent and the physician has adequate training and skills to deal with the situation without escalating the violence. If the physician feels unable to deal effectively with either patient because of the dual relationship, referral to another qualified physician is preferred.
MESH: Confidentiality-; Referral-and-Consultation; United-States
MESH: *Domestic-Violence-prevention-and-control; *Family-Practice
TG: Female; Human; Male; Support,-Non-U.S.-Gov't
PT: CONSENSUS-DEVELOPMENT-CONFERENCE; GUIDELINE; JOURNAL-ARTICLE; PRACTICE-GUIDELINE; REVIEW
AN: 97438220
UD: 9711
SB: AIM

3 of 9
Marked in Search: #9
TI: Compensation for subjects of medical research: the moral rights of patients and the power of research ethics committees.
AU: Guest-S
AD: University College, London.
SO: J-Med-Ethics. 1997 Jun; 23(3): 181-5
this source is not Available in S.J.M.C.Library
ISSN: 0306-6800
PY: 1997
LA: ENGLISH
CP: ENGLAND
AB: Awareness of the morally significant distinction between research and innovative therapy reveals serious gaps in the legal provision for compensation in the UK for injured subjects of medical research. Major problems are limitations inherent in negligence actions and a culture that emphasises indemnifying researchers before compensating victims. Medical research morally requires compensation on a no-fault basis even where there is proper consent on the part of the research subject. In particular, for drug research, there is insufficient provision in the current patient guidelines of the Association of the British Pharmaceutical Industry, since they make "no legal commitment" to paying compensation for injury to patient subjects. There is a need for the provision of both adequate insurance and contractual arrangements for making payments. The solution is for Local Research Ethics Committees (LRECs) to make use of their power to withhold approval of medical research where compensation is not legally enforceable.
MESH: England-
MESH: *Clinical-Trials-legislation-and-jurisprudence; *Ethics-Committees-legislation-and-jurisprudence; *Human-Experimentation; *Insurance,-Liability-legislation-and-jurisprudence; *Morals-
TG: Human
PT: JOURNAL-ARTICLE
AN: 97364041
UD: 9710

4 of 9
Marked in Search: #9
TI: Implications of managed care for health systems, clinicians, and patients.

AU: Fairfield-G; Hunter-DJ; Mechanic-D; Rosleff-F
AD: Nuffield Institute for Health, University of Leeds.
SO: BMJ. 1997 Jun 28; 314(7098): 1895-8
ISSN: 0959-8138
PY: 1997
LA: ENGLISH
CP: ENGLAND
AB: The rhetoric and realities of managed care are easily confused. The rapid growth of managed care in the United States has had many implications for patients, doctors, employers, state and federal programmes, the health insurance industry, major medical institutions, medical research, and vulnerable patient populations. It has restricted patients' choice of doctors and limited access to specialists, reduced the professional autonomy and earnings of doctors, shifted power from the non-profit to the for-profit sectors and from hospitals and doctors to private corporations. It has also raised issues about the future structuring and financing of medical education and research and about practice ethics. However, managed care has also accorded greater prominence to the assessment of patient satisfaction, profiling and monitoring of doctors' work, the use of clinical guidelines and quality assurance procedures and indicated the potential to improve the integration and outcome of care.
MESH: Choice-Behavior; Great-Britain; Health-Care-Costs; Health-Maintenance-Organizations; Managed-Care-Programs-economics; Managed-Care-Programs-legislation-and-jurisprudence; Managed-Care-Programs-organization-and-administration; Practice-Guidelines; Quality-of-Health-Care; State-Medicine-economics; State-Medicine-organization-and-administration
MESH: *Managed-Care-Programs; *State-Medicine
TG: Human
PT: JOURNAL-ARTICLE
AN: 97367435
UD: 9710
SB: AIM

5 of 9
Marked in Search: #10
TI: Emergency physicians and sexual involvement with patients: an Ontario survey.
AU: Ovens-HJ; Permaul-Woods-JA
AD: Division of Emergency Services, Mount Sinai Hospital, Toronto, Ont.
SO: CMAJ. 1997 Sep 15; 157(6): 663-9
this source is not Available in S.J.M.C.Library
ISSN: 0820-3946
PY: 1997
LA: ENGLISH
CP: CANADA
AB: OBJECTIVE: To describe Ontario emergency physicians' knowledge of colleagues' sexual involvement with patients and former patients, their own personal experience of such involvement, and their attitudes toward postvisit relationships. DESIGN: Mailed survey. SETTING: Ontario. PARTICIPANTS: Emergency physicians practising in Ontario. RESULTS: Of 974 eligible mailed surveys, 599 (61.5%) were returned. Of these respondents, 52 (8.7%) reported being aware of a colleague in emergency practice who had been sexually involved with a patient or former patient. When describing their own behaviour, 37 respondents (6.2%) reported sexual involvement with a former patient. However, of this group, only 9 (25.0%) had met the patient in an emergency department. Thus, of the total number of respondents, only 1.5% (9/599) reported sexual involvement arising out of an emergency department visit. Most respondents (82.4%) agreed that it is inappropriate behaviour to ask a patient for a date after an emergency assessment and before the patient's departure, and 66.4% felt that it is

inappropriate to contact the patient after discharge. However, only 10.6% believed it to be unacceptable to request a social meeting after encountering a patient previously cared for in the emergency department in a nonprofessional setting. Most respondents (96.5%) did not believe that sexual involvement could ever be therapeutic for the patient. However, only 66% felt that it was always an abuse of power and 62.4% supported zero tolerance of all sexual involvement between physicians and patients. CONCLUSIONS: Vague regulatory guidelines currently in place have failed to dispel confusion regarding what is acceptable social behaviour for physicians providing emergency care. Our results support the need for clarification, and suggest a basis for guidelines that would be acceptable to the emergency medical community: that an emergency visit should not form the basis for the initiation of personal or sexual relationships, yet neither should it preclude their development in nonmedical settings.
MESH: Adult-; Attitude-of-Health-Personnel; Ethics,-Medical; Middle-Age; Ontario-; Questionnaires-
MESH: *Emergency-Medicine; *Physician-Patient-Relations; *Sex-Behavior
TG: Female; Human; Male; Support,-Non-U.S.-Gov't
PT: JOURNAL-ARTICLE
AN: 97452762
UD: 9712
SB: AIM

6 of 9
Marked in Search: #10
TI: Ethical, social, and legal issues surrounding studies of susceptible populations and individuals.
AU: Soskolne-CL
AD: Department of Public Health Sciences, University of Alberta, Edmonton, Canada. colin.soskolne@ualberta.ca
SO: Environ-Health-Perspect. 1997 Jun; 105 Suppl 4: 837-41
this source is not Available in S.J.M.C.Library
ISSN: 0091-6765
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: Calls for professional accountability have resulted in the development of ethics guidelines by numerous specialty and subspecialty groups of scientists. Indeed, guidelines among some health professions now address vulnerable and dependent groups: but these are silent on issues related to biomarkers. In parallel, attention has been drawn to human rights concerns associated with attempts to detect hypersusceptible workers, especially in democratic countries. Despite this, concern for vulnerable populations grows as advances in biomarker technology make the identification of genetic predisposition and susceptibility markers of both exposure and outcome more attainable. In this article, the principles derived from the ethical theory of utilitarianism provide the basis for principle-based ethical analysis. In addition, the four principles of biomedical ethics--respect for autonomy, beneficence, nonmaleficence, and social justice--are considered for biomarker studies. The need for a context in which ethical analysis is conducted and from which prevailing social values are shown to drive decisions of an ethical nature is emphasized; these include statutory regulation and law. Because biomarker studies can result in more harm than good, special precautions to inform research participants prior to any involvement in the use of biomarkers are needed. In addition, safeguards to maintain the privacy of data derived from biomarker studies must be developed and implemented prior to the application of these new technologies. Guidelines must be expanded to incorporate ethical, social, and legal considerations surrounding the introduction of new technologies for studying susceptible populations and individuals who may be vulnerable to environmental exposures.
MESH: Biological-Markers

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MESH: *Environmental-Monitoring; *Ethics-;
*Occupational-Health-legislation-and-jurisprudence
TG: Human
PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
RN: 0
NM: Biological-Markers
AN: 97399442
UD: 9711

                                                                  7 of 9
                                                     Marked in Search: #10
TI: Informed consent. Explicit guidance is required on valid exemptions for
need for ethical review [letter]
AU: Woodcock-T; Norman-J
SO: BMJ. 1997 Jul 26; 315(7102): 250
ISSN: 0959-8138
PY: 1997
LA: ENGLISH
CP: ENGLAND
MESH: Clinical-Trials; Ethics,-Medical; Practice-Guidelines
MESH: *Ethics-Committees; *Informed-Consent
TG: Human
PT: LETTER
AN: 97397223
UD: 9711
SB: AIM

                                                                  8 of 9
                                                     Marked in Search: #10
TI: Proposed guidelines for speakers discussing medications and other products.
AU: Daniel-CR-3rd; Elewski-BE; Scher-RK
AD: University of Mississippi Medical Center, Jackson, USA.
SO: Cutis. 1997 May; 59(5): 271-2
    This source is Available in S.J.M.C Library
    Call Number: From:1971, 1985+
SB: AIM
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Mp-2 ①

1 of 8
Marked in Search: #8

TI: Research ethics. NIH examines standards for consent [news]
AU: Marshall-E
SO: Science. 1998 Jun 12; 280(5370): 1688
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1937-1989
ISSN: 0036-8075
PY: 1998
LA: ENGLISH
CP: UNITED-STATES
MESH: Clinical-Trials-standards; Guidelines-; Human-Experimentation; Research-standards; United-States
MESH: *Bioethics-; *Informed-Consent; *Mental-Competency; *National-Institute-of-Mental-Health-U.S.-standards; *National-Institutes-of-Health-U.S.-standards; *Professional-Staff-Committees-standards
TG: Human
PT: NEWS
AN: 98314401
UD: 9809

2 of 8
Marked in Search: #8

TI: Critical ethical issues in clinical trials with xenotransplants.
AU: Vanderpool-HY
AD: Institute for the Medical Humanities, University of Texas Medical Branch, Galveston 77555-13122, USA.
SO: Lancet. 1998 May 2; 351(9112): 1347-50
This source is Available in S.J.M.C Library
Call Number: From: 1930+
ISSN: 0140-6736
PY: 1998
LA: ENGLISH
CP: ENGLAND
MESH: Guidelines-; Informed-Consent; Patient-Advocacy
MESH: *Clinical-Trials; *Ethics,-Medical; *Transplantation,-Heterologous
TG: Human
PT: JOURNAL-ARTICLE
AN: 98305965
UD: 9809
SB: AIM

3 of 8
Marked in Search: #8

TI: Ethical debate. Too drunk to care?
AU: Cressey-DM; Rigter-H; Rees-G; Walsh-P
AD: Anaesthetic Department, Royal Hallamshire Hosptial, Sheffield, S10 2JF. D.M.Cressey@Sheffield.ac.uk
SO: BMJ. 1998 May 16; 316(7143): 1515-7
ISSN: 0959-8138
PY: 1998

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LA: ENGLISH
CP: ENGLAND
MESH: Clinical-Competence; Emergencies-; Morals-; Practice-Guidelines;
Professional-Practice; Risk-Assessment
MESH: *Alcohol-Drinking; *Ethics,-Medical; *Physician-Impairment
TG: Human
PT: JOURNAL-ARTICLE
AN: 98248391
UD: 9808
SB: AIM

                                                                      4 of 8
                                                     Marked in Search: #8
TI: Implementation of guidelines for No-CPR orders by a general medicine unit
in a teaching hospital [see comments]
CM: Comment in: Aust N Z J Med 1997 Aug;27(4):369-70
AU: Lowe-J; Kerridge-I
AD: General Medicine Unit, John Hunter Hospital, Newcastle, NSW.
SO: Aust-N-Z-J-Med. 1997 Aug; 27(4): 379-83
    This source is Available only few issues in S.J.M.C. Library
    Call Number: From: 1980-1987
ISSN: 0004-8291
PY: 1997
LA: ENGLISH
CP: AUSTRALIA
AB: BACKGROUND: No-cardiopulmonary resuscitation (CPR) orders are frequently
used to limit the use of cardiopulmonary resuscitation in patients who die in
hospital. International research has consistently highlighted major
deficiencies in the formulation, documentation and communication of such
orders. There has been little Australian research into No-CPR orders and the
impact of clinical guidelines. AIMS: This audit aimed to examine compliance
with published guidelines for No-CPR orders previously developed by the
hospital Clinical Ethics Committee. METHODS: The notes of all patients who died
while under the care of the General Medicine Unit during June-December 1994
were reviewed to evaluate the use of No-CPR orders. Adherence to hospital
No-CPR guidelines was evaluated as well as the principal diagnosis, age, level
of care and competence of patients to state their wishes. RESULTS: A No-CPR
order was documented in 61% (n = 40) of the 66 patients who died during this
period. Of these patients 80% were judged to be incompetent and were unable to
be involved in decisions not to resuscitate. There was substantial compliance
with the guidelines
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SilverPlatter 3.11 MEDLINE (R) 1/98-9/98

1 of 6
Marked in Search: #3

✓ TI: Ethical practice in managed care: a dose of realism.
AU: Hall-MA; Berenson-RA
AD: Wake Forest University School of Medicine, Winston-Salem, North Carolina 27157-1063, USA.
SO: Ann-Intern-Med. 1998 Mar 1; 128(5): 395-402
This source is Available in S.J.M.C Library
Call Number: From: 1972+
ISSN: 0003-4819
PY: 1998
LA: ENGLISH
CP: UNITED-STATES
AB: This article examines the ethics of medical practice under managed care from a pragmatic perspective that gives physicians more useful guidance than do existing ethical statements. The article begins with a framework for constructing a realistic set of ethical principles, namely, that medical ethics derives from physicians' role as healers; that ethical statements are primarily aspirational, not regulatory; and that preserving patient trust is the primary objective. The following concrete ethical guidelines are presented: Financial incentives should influence physicians to maximize the health of the group of patients under their care; physicians should not enter into incentive arrangements that they are embarrassed to describe accurately to their patients; physicians should treat each patient impartially without regard to source of payment, consistent with the physician's own treatment style; if physicians depart from this ideal, they should inform their patients honestly; and it is desirable, although not mandatory, to differentiate medical treatment recommendations from insurance coverage decisions by clearly assigning authority over these different roles and by physicians advocating for recommended treatment that is not covered.
MESH: Health-Care-Rationing; Patient-Advocacy; Physician-Patient-Relations; Physician's-Role; Reimbursement,-Incentive
MESH: *Ethics,-Medical; *Managed-Care-Programs
TG: Human
PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
AN: 98138825
UD: 9805
SB: AIM

2 of 6
Marked in Search: #3

TI: Ethical and institutional review board issues.
AU: Skolnick-BE
AD: Department of Neurology, Pennsylvania Hospital, Philadelphia 19107, USA.
SO: Adv-Neurol. 1998; 76: 253-62
this source is serial publication, available only few issues in S.J.M.C.Library
Call Number: From:1973-1988
ISSN: 0091-3952
PY: 1998
LA: ENGLISH
CP: UNITED-STATES

AB: IRBs provide an important role in the protection of research subjects/patients. Research investigators have an inherent potential conflict of interest as health care professionals; as physicians, they are dedicated to promoting the welfare of individual patients, whereas as researchers, they seek knowledge that can be generalized and is applicable to persons other than the individual patient under study. The second goal may be in conflict with the first. IRBs have the paramount responsibility of protecting the rights and welfare of human research subjects. Although the IRB system is not perfect, conscientious IRBs reassure the public that the rights and welfare of human subjects are seriously considered by people who do not have a vested interest in the outcome of the research. By exercising their responsibilities, IRBs promote the protection of human subjects. IRB approval provides a significant affirmation of the scientific and ethical qualities of research, and therefore offers important validation to research and research investigators. IRBs, acting in accordance with the guiding principles of the Belmont Report and within the regulatory <u>guidelines</u> of 45.CFR.46, are intended to provide balance between society's interest in advancing scientific knowledge and the mandate to protect the rights and welfare of human subjects.
MESH: Anticonvulsants-adverse-effects; Helsinki-Declaration; Informed-Consent
MESH: *Anticonvulsants-therapeutic-use; *Clinical-Trials-standards;
*<u>Ethics,-Medical</u>; *Professional-Staff-Committees-trends
TG: Human
PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
RN: 0
NM: Anticonvulsants
AN: 98072764
UD: 9804

3 of 6
Marked in Search: #3

TI: <u>Ethics</u> group drafts guidelines

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country and/or by International Convention.

                                                                      1 of 4
                                                         Marked in Search: #3
TI: Ethics group drafts guidelines for control of genetic material and
information [news]
AU: Stephenson-J
SO: JAMA. 1998 Jan 21; 279(3): 184
    This source is Available in S.J.M.C Library
    Call Number: From: 1918+
ISSN: 0098-7484
PY: 1998
LA: ENGLISH
CP: UNITED-STATES
MESH: *Ethics-; *Genome,-Human; *Guidelines-; *Human-Genome-Project
TG: Human
PT: NEWS
AN: 98099561
UD: 9803
SB: AIM

                                                                      2 of 4
                                                         Marked in Search: #3
TI: Genetic testing for cancer risk: how to reconcile the conflicts.
AU: Kodish-E; Wiesner-GL; Mehlman-M; Murray-T
AD: Department of Pediatrics, Center for Biomedical Ethics, Case Western
Reserve University School of Medicine, Cleveland, OH, USA.
SO: JAMA. 1998 Jan 21; 279(3): 179-81
    This source is Available in S.J.M.C Library
    Call Number: From: 1918+
ISSN: 0098-7484
PY: 1998
LA: ENGLISH
CP: UNITED-STATES
MESH: Breast-Neoplasms-diagnosis; Breast-Neoplasms-genetics;
Genetic-Screening-economics; Genetic-Screening-psychology;
Heterozygote-Detection; Medical-Oncology-standards;
National-Institutes-of-Health-U.S.; Neoplasms-diagnosis; Risk-Factors;
Societies,-Medical; United-States
MESH: *Ethics,-Medical; *Genetic-Screening-standards; *Neoplasms-genetics;
*Practice-Guidelines
TG: Human; Support,-Non-U.S.-Gov't
PT: JOURNAL-ARTICLE
AN: 98099559
UD: 9803
SB: AIM

                                                                      3 of 4
                                                         Marked in Search: #3
TI: Indian guidelines allow limited gene screening [news]
AU: Jayaraman-KS
SO: Nature. 1998 Jan 8; 391(6663): 115
    This source is Available only few issues in S.J.M.C. Library
    Call Number: From: 1956-1993
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ISSN: 0028-0836
PY: 1998
LA: ENGLISH
CP: ENGLAND
MESH: Fetus-; India-; Research-standards
MESH: *Ethics,-Medical; *Genetic-Screening; *Guidelines-
TG: Animal; Human
PT: NEWS
AN: 98089028
UD: 9803

                                                                  4 of 4
                                                        Marked in Search: #3
TI: Synopsis of a practical guide: guidelines for ethics committees.
AU: Mulvey-B
AD: Nova Southeastern University, Fort Lauderdale, Florida, USA.
SO: J-Fla-Med-Assoc. 1997 Nov; 84(8): 506-9
    this source is not Available in S.J.M.C.Library
ISSN: 0015-4148
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Bioethics-; Education,-Continuing; Ethics-Committees-organization-and-
administration; Ethics,-Medical-education; Organizational-Culture;
Organizational-Innovation; Organizational-Objectives; Organizational-Policy;
Policy-Making
MESH: *Ethics-Committees; *Ethics,-Medical; *Guidelines-
TG: Human
PT: JOURNAL-ARTICLE
AN: 98064614
UD: 9803
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1 of 27
Marked in Search: #5

TI: The rationale and ethics of medication-free research in schizophrenia [see comments]
CM: Comment in: Arch Gen Psychiatry 1997 May;54(5):412-3. Comment in: Arch Gen Psychiatry 1997 May;54(5):415-6
AU: Carpenter-WT Jr; Schooler-NR; Kane-JM
AD: Department of Psychiatry, University of Maryland School of Medicine, Baltimore, USA.
SO: Arch-Gen-Psychiatry. 1997 May; 54(5): 401-7
    This source is Available in S.J.M.C Library
    Call Number: From: 1959+
ISSN: 0003-990X
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: Schizophrenia research is receiving intense scrutiny from an ethical perspective. Medication-free protocols present a most vexing dilemma in that they greatly enhance the opportunity for advancing knowledge but also raise the prospect of withholding known effective treatment. In this article, we discuss the purpose of medication-free protocols in new drug development and nontreatment research. Potential benefits and risks associated with drug discontinuation are evaluated, and methods for minimizing risk and increasing benefits are proposed as guidelines for the protection of individual subjects. The complex problem of informed consent also is addressed. Medication-free research in schizophrenia is difficult, but it can be conducted relatively, safely with freely consenting, competent subjects. Assurance that studies meet this standard is required. We believe that such investigations can meet high standards of ethics and subject protection, and that a radical revision of procedures for research review and implementation is not indicated.
MESH: Acute-Disease; Clinical-Protocols-standards; Clinical-Trials-standards; Informed-Consent; Patient-Selection; Risk-Assessment; Schizophrenia-drug-therapy; Schizophrenia-therapy; Schizophrenic-Psychology
MESH: *Antipsychotic-Agents-therapeutic-use; *Ethics,-Medical; *Research-Design-standards; *Schizophrenia-
TG: Human; Support,-U.S.-Gov't,-P.H.S.
PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
CN: MH40279MHNIMH; MH35996MHNIMH; MH45156MHNIMH
RN: 0
NM: Antipsychotic-Agents
AN: 97296623
UD: 9708
SB: AIM

2 of 27
Marked in Search: #5

TI: Ethical policy guidelines development for general hospital nurses.
AU: Commons-L; Baldwin-S
AD: Department of Nursing, Faculty of Health and Human Sciences Edith Cowan University, Bunbury, Western Australia.
SO: Int-J-Nurs-Stud. 1997 Feb; 34(1): 1-8
    this source is not Available in S.J.M.C.Library

ISSN: 0020-7489
PY: 1997
LA: ENGLISH
CP: ENGLAND
AB: The purpose of this position paper is to examine ethical situations involving nurses, and provide suggestions about how to work through ethical problems they may encounter. Ethics in the nursing profession is ubiquitous. Nurses need to be aware of the provided codes so any ambiguity regarding ethical dilemmas can be resolved. Ethical situations which call for such judgements include: equity, confidentiality, honesty and justice. Resolution of such situations requires consistent education to ensure full awareness of societal values which are projected through the care of clients. This will aid in the provision of quality care and ensure that a holistic approach is achieved to maintain high standards of care.
MESH: Clinical-Competence; Confidentiality-; Guidelines-; Health-Status; Patient-Advocacy; Quality-of-Health-Care; Social-Values
MESH: *Ethics,-Nursing; *Nursing-Care-standards; *Nursing-Staff,-Hospital
TG: Human; Support,-Non-U.S.-Gov't
PT: JOURNAL-ARTICLE
AN: 97207879
UD: 9708
SB: NURSING

3 of 27
Marked in Search: #5
TI: Recommended guidelines for reviewing, reporting, and conducting research on in-hospital resuscitation: the in-hospital 'Utstein style': a statement for healthcare professionals from the American Heart Association, the European Resuscitation Council, the Heart and Stroke Foundation of Canada, the Australian Resuscitation Council, and the Resuscitation Councils of Southern Africa.
AU: Cummins-RO; Chamberlain-D; Hazinski-MF; Nadkarni-V; Kloeck-W; Kramer-E; Becker-L; Robertson-C; Koster-R; Zaritsky-A; Bossaert-L; Ornato-JP; Callanan-V; Allen-M; Steen-P; Connolly-B; Sanders-A; Idris-A; Cobbe-S
SO: Circulation. 1997 Apr 15; 95(8): 2213-39
This source is Available in S.J.M.C Library
Call Number: From: 1950+
ISSN: 0009-7322
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Adolescence-; Adult-; Aged-; Aged,-80-and-over; Cardiopulmonary-Resuscitation-methods; Cardiopulmonary-Resuscitation-standards; Child-; Child,-Preschool; Comorbidity-; Data-Collection-methods; Data-Collection-standards; Demography-; Emergency-Medical-Services-methods; Emergency-Service,-Hospital-standards; Ethics,-Medical; Evaluation-Studies; Follow-Up-Studies; Forms-and-Records-Control; Health-Services-Research-methods; Heart-Arrest-epidemiology; Infant-; Infant,-Newborn; Middle-Age; Outcome-and-Process-Assessment-Health-Care-standards; Resuscitation-methods; Severity-of-Illness-Index
MESH: *Emergency-Medical-Services-standards; *Health-Services-Research-standards; *Heart-Arrest-therapy; *Hospital-Administration-standards; *Medical-Records-standards; *Quality-Assurance,-Health-Care-standards; *Resuscitation-standards
TG: Female; Human; Male; Support,-Non-U.S.-Gov't
PT: GUIDELINE; JOURNAL-ARTICLE; PRACTICE-GUIDELINE
AN: 97278960
UD: 9707
SB: AIM

4 of 27
Marked in Search: #5

✓ TI: Medical Council of India on hysterectomy in the mentally retarded [news]
AU: Pandya-SK
SO: Natl-Med-J-India. 1997 Jan-Feb; 10(1): 36
This source is Available in S.J.M.C Library
Call Number: From: 1988+
ISSN: 0970-258X
PY: 1997
LA: ENGLISH
CP: INDIA
MESH: Ethics,-Medical; India-; Practice-Guidelines
MESH: *Hysterectomy-; *Mental-Retardation
TG: Female; Human
PT: NEWS
AN: 97222711
UD: 9707

5 of 27
Marked in Search: #5

✓ TI: Guidelines for placement of percutaneous endoscopic gastrostomy tube [letter]
AU: Stewart-JA
SO: Lancet. 1997 Mar 29; 349(9056): 958
This source is Available in S.J.M.C Library
Call Number: From: 1930+
ISSN: 0140-6736
PY: 1997
LA: ENGLISH
CP: ENGLAND
MESH: Algorithms-; Practice-Guidelines; Quality-of-Life
MESH: *Enteral-Nutrition; *Ethics,-Medical; *Gastrostomy-; *Intubation,-Gastrointestinal
TG: Human
PT: LETTER
AN: 97247148
UD: 9707
SB: AIM

6 of 27
Marked in Search: #5

TI: Guidelines for placement of percutaneous endoscopic gastrostomy tube [letter]
AU: Rosner-F
SO: Lancet. 1997 Mar 29; 349(9056): 958
This source is Available in S.J.M.C Library
Call Number: From: 1930+
ISSN: 0140-6736
PY: 1997
LA: ENGLISH
CP: ENGLAND
MESH: Algorithms-; Practice-Guidelines; Quality-of-Life
MESH: *Enteral-Nutrition; *Ethics,-Medical; *Gastrostomy-; *Intubation,-Gastrointestinal
TG: Human
PT: LETTER
AN: 97247149
UD: 9707
SB: AIM

7 of 27
Marked in Search: #5

TI: Confidentiality and the AMA's new code of ethics: an imprudent formulation? [letter]
AU: Komesaroff-PA
SO: Med-J-Aust. 1997 Feb 17; 166(4): 221
This source is Available in S.J.M.C Library
Call Number: From: 1966+
ISSN: 0025-729X
PY: 1997
LA: ENGLISH
CP: AUSTRALIA
MESH: Australia-; Public-Health
MESH: *Confidentiality-; *Ethics,-Medical; *Practice-Guidelines; *Societies,-Medical
TG: Human
PT: LETTER
AN: 97219254
UD: 9706

8 of 27
Marked in Search: #5

TI: Professionalism in health care delivery.
AU: Shapiro-R
SO: Wis-Med-J. 1997 Jan; 96(1): 28-31
this source is not Available in S.J.M.C.Library
ISSN: 0043-6542
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Ethics,-Medical; Interprofessional-Relations; Physician-Patient-Relations; Practice-Guidelines; United-States
MESH: *Delivery-of-Health-Care-trends; *Professional-Practice
TG: Human
PT: JOURNAL-ARTICLE
AN: 97172728
UD: 9706

9 of 27
Marked in Search: #5

TI: World Medical Association declaration of Helsinki. Recommendations guiding physicians in biomedical research involving human subjects [see comments]
CM: Comment in: JAMA 1997 Mar 19;277(11):922-3
SO: JAMA. 1997 Mar 19; 277(11): 925-6
This source is Available in S.J.M.C Library
Call Number: From: 1918+
ISSN: 0098-7484
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: Ethics,-Medical; Guidelines-; Informed-Consent
MESH: *Evaluation-Studies; *Helsinki-Declaration; *Human-Experimentation
TG: Human
PT: JOURNAL-ARTICLE
AN: 97216044
UD: 9706
SB: AIM

10 of 27
Marked in Search: #5

TI: Institutional review board approval and publication of human research results [see comments]
CM: Comment in: JAMA 1997 Mar 19;277(11):922-3
AU: Amdur-RJ; Biddle-C
AD: Dartmouth-Hitchcock Medical Center, Lebanon, NH 03756, USA.
robert.amdur@hitchcock.org
SO: JAMA. 1997 Mar 19; 277(11): 909-14
This source is Available in S.J.M.C Library
Call Number: From: 1918+
ISSN: 0098-7484
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
AB: OBJECTIVE: To determine if journals' instructions for authors require that manuscripts being considered for publication indicate that studies involving human subjects had appropriate institutional review board (IRB) approval. DESIGN: A descriptive study of the ethical guidelines published in the Instructions for Authors sections of the 102 English-language biomedical research journals listed in the 1995 Abridged Index Medicus. INTERVENTION: Literature review. MAIN OUTCOME MEASURE: Policy regarding IRB approval of studies that involve human subjects. RESULTS: Of the 102 journals surveyed, 48 (47%) require IRB approval of studies involving human subjects as a prerequisite for publication, and 25 (24%) do not present or refer the author to any information related to human research ethics. Of the remaining journals, 15 (15%) referred authors to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, 3 (3%) to the Declaration of Helsinki, and 10 (10%) simply indicated that informed consent should be obtained. There was only 1 medical specialty (anesthesiology) in which all the representative journals presented the same ethical requirement. In the 48 journals that clearly required IRB approval of studies, 37 (77%) documented IRB approval with a statement in the manuscript, 7 (15%) required a separate signed statement from the author, and 4 (8%) did not mention a method of documentation. CONCLUSIONS: The results of this study suggest that about half of the 102 English-language biomedical research journals listed in the 1995 Abridged Index Medicus do not publish guidelines indicating that IRB approval of studies involving human research subjects is a requirement for publication. The manner in which publication requirements related to ethical standards are presented in biomedical research journals is extremely variable.
MESH: Documentation-; Ethics,-Medical; Helsinki-Declaration; Informed-Consent; Specialties,-Medical-standards
MESH: *Evaluation-Studies; *Human-Experimentation; *Periodicals-standards; *Professional-Staff-Committees; *Publishing-standards
TG: Human
PT: JOURNAL-ARTICLE
AN: 97216040
UD: 9706
SB: AIM

11 of 27
Marked in Search: #5

TI: Ethical issues in the development and use of guidelines for clinical practice.
AU: Redman-BK
AD: School of Nursing, University of Connecticut, Storrs, USA.
SO: J-Clin-Ethics. 1996 Fall; 7(3): 251-6
this source is not Available in S.J.M.C.Library
ISSN: 1046-7890
PY: 1996
LA: ENGLISH
CP: UNITED-STATES

AB: In order to serve the purposes expected of them, practice guidelines must be more than summaries of available research; they must also challenge the values that are implicit in the way practice questions have been framed and outcomes have been chosen. The IOM has defined desirable attributes of practice guidelines, focused on the characteristics of measurement and implementation. It is also desirable for guidelines to meet certain ethical criteria.

MESH: Anemia,-Sickle-Cell-diagnosis; Anemia,-Sickle-Cell-therapy; Counseling-; Health-Care-Reform-standards; Neoplasms-physiopathology; Pain,-Intractable-therapy; United-States; United-States-Agency-for-Health-Care-Policy-and-Research

MESH: *Ethics,-Medical; *Practice-Guidelines-standards

TG: Human

PT: JOURNAL-ARTICLE

AN: 97135659

UD: 9705

12 of 27
Marked in Search: #5

TI: Ethically justified, clinically comprehensive guidelines for percutaneous endoscopic gastrostomy tube placement.

AU: Rabeneck-L; McCullough-LB; Wray-NP

AD: Department of Veterans Affairs, Houston, Texas, USA.

SO: Lancet. 1997 Feb 15; 349(9050): 496-8
This source is Available in S.J.M.C Library
Call Number: From: 1930+

ISSN: 0140-6736

PY: 1997

LA: ENGLISH

CP: ENGLAND

AB: Guidelines for the placement of percutaneous endoscopic gastrostomy (PEG) tubes are not available. We developed a decision-making algorithm by integrating the medical and ethical dimensions of the decision. According to our algorithm, physicians should not offer PEG tubes to patients with anorexia-cachexia syndromes. For patients with permanent vegetative states, physicians should offer and recommend against the procedure. For patients who have dysphagia without other deficits in quality of life, physicians should offer and recommend the procedure. For the the remaining patients who have dysphagia with other deficits in quality of life, the physician's role is to provide non-directive counselling regarding the short and long-term consequences of a trial of PEG tube feeding.

MESH: Algorithms-; Counseling-; Decision-Making; Deglutition-Disorders-therapy; Gastrostomy-; Practice-Guidelines

MESH: *Enteral-Nutrition; *Ethics,-Medical

TG: Human

PT: JOURNAL-ARTICLE

AN: 97192999

UD: 9705

SB: AIM

13 of 27
Marked in Search: #5

TI: Public confidence in public health research ethics [comment]

CM: Comment on: Public Health Rep 1997 Jan-Feb;112(1):29-32

AU: Mariner-WK

AD: Boston University Schools of Public Health and Medicine, MA, USA.

SO: Public-Health-Rep. 1997 Jan-Feb; 112(1): 33-6
This source is Available only few issues in S.J.M.C. Library
Call Number: From:1949-1984

ISSN: 0033-3549

PY: 1997

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LA: ENGLISH
CP: UNITED-STATES
MESH: Human-Experimentation; Informed-Consent
MESH: *Attitude-to-Health; *Ethics,-Medical; *Guidelines-;
*Public-Health-standards; *Research-standards
TG: Human
PT: COMMENT; JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL
AN: 97171012
UD: 9705
SB: AIM

                                                          14 of 27
                                                Marked in Search: #5
TI: Thinking about a medical school core curriculum for medical ethics and law
[editorial; comment]
CM: Comment on: J Med Ethics  1996 Dec;22(6 ):325-6
AU: Gillon-R
SO: J-Med-Ethics. 1996 Dec; 22(6): 323-4
    this source is not Available in S.J.M.C.Library
ISSN: 0306-6800
PY: 1996
LA: ENGLISH
CP: ENGLAND
MESH: Great-Britain; Guidelines-
MESH: *Curriculum-; *Education,-Medical,-Undergraduate-organization-and-
administration; *Ethics,-Medical; *Legislation,-Medical
TG: Human
PT: COMMENT; EDITORIAL
AN: 97120443
UD: 9705

                                                          15 of 27
                                                Marked in Search: #5
TI: Torture, ethics and health professionals [editorial]
AU: Ray-I
SO: J-Indian-Med-Assoc. 1996 Jul; 94(7): 250
    this source is not Available in S.J.M.C.Library
ISSN: 0019-5847
PY: 1996
LA: ENGLISH
CP: INDIA
MESH: *Ethics,-Medical; *Human-Rights; *Practice-Guidelines; *Torture-
TG: Human
PT: EDITORIAL
AN: 97171898
UD: 9705

                                                          16 of 27
                                                Marked in Search: #5
TI: Physician-operated networks and the new antitrust guidelines.
AU: Kuttner-R
AD: The American Prospect, Cambridge, MA 02138, USA.
SO: N-Engl-J-Med. 1997 Jan 30; 336(5): 386-91
    This source is Available in S.J.M.C Library
    Call Number: From: 1945+
ISSN: 0028-4793
PY: 1997
LA: ENGLISH
CP: UNITED-STATES
MESH: American-Medical-Association; Community-Networks-economics;
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Economic-Competition-legislation-and-jurisprudence; Ethics,-Medical; Fees,-Medical-legislation-and-jurisprudence; Hospital-Physician-Joint-Ventures-economics; Hospital-Physician-Joint-Ventures-legislation-and-jurisprudence; Independent-Practice-Associations-economics; Preferred-Provider-Organizations-economics; Preferred-Provider-Organizations-legislation-and-jurisprudence; Professional-Autonomy; United-States; United-States-Federal-Trade-Commission
MESH: *Antitrust-Laws; *Community-Networks-legislation-and-jurisprudence; *Independent-Practice-Associations-legislation-and-jurisprudence
PT: JOURNAL-ARTICLE
AN: 97163333
UD: 9704
SB: AIM

17 of 27
Marked in Search: #5

TI: Informed consent in human experimentation before the Nuremberg code.
✓ AU: Vollmann-J; Winau-R
AD: Institute of the History of Medicine, Free University of Berlin.
SO: BMJ. 1996 Dec 7; 313(7070): 1445-9
ISSN: 0959-8138
PY: 1996
LA: ENGLISH
CP: ENGLAND
AB: The issue of ethics with respect to medical experimentation in Germany during the 1930s and 1940s was crucial at the Nuremberg trials and related trials of doctors and public health officials. Those involved in horrible crimes attempted to excuse themselves by arguing that there were no explicit rules governing medical research on human beings in Germany during the period and that research practices in Germany were not different from those in allied countries. In this context the Nuremberg code of 1947 is generally regarded as the first document to set out ethical regulations in human experimentation based on informed consent. New research, however, indicates that ethical issues of informed consent in guidelines for human experimentation were recognised as early as the nineteenth century. These guidelines shed light on the still contentious issue of when the concepts of autonomy, informed consent, and therapeutic and non-therapeutic research first emerged. This issue assumes renewed importance in the context of current attempts to assess liability and responsibility for the abuse of people in various experiments conducted since the second world war in the United States, Canada, Russia, and other nations.
MESH: Germany-; Government-; History-of-Medicine,-20th-Cent.; Patient-Advocacy; Practice-Guidelines; War-Crimes-history
MESH: *Ethics,-Medical; *Human-Experimentation-history; *Informed-Consent; *War-Crimes
TG: Human; Support,-Non-U.S.-Gov't
PT: HISTORICAL-ARTICLE; JOURNAL-ARTICLE
AN: 97128675
UD: 9703
SB: AIM

18 of 27
Marked in Search: #5

TI: Eying guidelines [letter]
✓ AU: Wensel-RH; Carter-AO; Walters-D; Beardall-S
SO: Can-Med-Assoc-J. 1996 Dec 15; 155(12): 1666, 1668
this source is not Available in S.J.M.C.Library
ISSN: 0008-4409
PY: 1996
LA: ENGLISH

CP: CANADA

MESH: Attitude-of-Health-Personnel; Canada-; Ethics,-Medical; Judgment-

MESH: *Practice-Guidelines-standards; *Quality-of-Health-Care-legislation-and-jurisprudence; *Societies,-Medical

PT: LETTER

AN: 97130567

UD: 9703

SB: AIM

19 of 27
Marked in Search: #5

TI: The changing nature of neonatal ethics in practice.

AU: Kinlaw-K

AD: Center for Ethics in Public Policy and the Professions, School of Medicine, Emory University, Atlanta, Georgia, USA.

SO: Clin-Perinatol. 1996 Sep; 23(3): 417-28

This source is Available in S.J.M.C Library
Call Number: From: 1976

ISSN: 0095-5108

PY: 1996

LA: ENGLISH

CP: UNITED-STATES

AB: This article overviews the current practice of neonatal care ethics. Tracing the evolving nature of neonatal care over the last few decades, the author reviews Rhoden's categories of approaches to neonatal care and raises questions about the nature of responsibility in neonatal decision making. The role of the parent or guardian and the importance of communication is explored. Current neonatal outcome studies are reviewed in considering what "best interests" means for the newborn. The article concludes by reviewing several issues raised by current court cases that may point to the future of ethical decision making in neonatal care.

MESH: Anencephaly-; Brain-Death; Guidelines-; Infant,-Low-Birth-Weight; Infant,-Newborn; Physician's-Role; Prognosis-; Resuscitation-Orders; United-States

MESH: *Ethics,-Medical; *Neonatology-

TG: Human

PT: JOURNAL-ARTICLE; REVIEW; REVIEW,-TUTORIAL

AN: 97038535

UD: 9702

20 of 27
Marked in Search: #5

TI: Do not resuscitate orders in the operating room.

AU: Craig-DB

AD: Department of Anesthesia, University of Manitoba and Health Sciences Centre, Winnipeg, Manitoba.

SO: Can-J-Anaesth. 1996 Aug; 43(8): 840-51

This source is Available in S.J.M.C Library
Call Number: From: 1966+

ISSN: 0832-610X

PY: 1996

LA: ENGLISH

CP: CANADA

AB: PURPOSE: The background to a current analysis of the management of "do not resuscitate" (DNR) orders in the operating room is reviewed, with an emphasis on the current status of resuscitation/DNR issues in Canada. SOURCE: The Joint Statement on Resuscitative Interventions published by the Canadian Medical Association and cooperating organizations and the report of the Senate of Canada Special Committee on Euthanasia and Assisted Suicide are examined for information relevant to the DNR issue. Guidelines on the management of DNR

MP-2

Main Identity

From: "sandhya srinivasan" <sandhya_srinivasan@vsnl.com>
To: <southasianmedicalethics@yahoogroups.com>
Sent: Sunday, July 27, 2003 11:27 AM
Subject: [southasianmedicalethics] liver donor dies

www.newindpress.com   Thursday July 10 2003 14:24 IST

Liver donor dies, sixth is transplant history

NEW DELHI: What was touted as the 25th successful liver transplant at Indraprastha Apollo last month turned into a tragedy with the donor's death nine days after the surgery. The death of the donor is a rare phenomenon and only sixth in the history of transplants in the world.

The 24-year-old donor, Subash, died on July 3 and was cremated around 10 am that day.

He had donated a part of his liver to South Indian film producer-director Srikant, who is the husband of film actress-turned-politician Jayaprada. Srikant, according to Apollo authorities, is recovering in the ICU of the hospital.

According to experts, while the recipient's death before or after the surgery is common, donor deaths are rare.

''Only six cases of deaths in donations of liver have been reported in the medical history. There is less than 0.1 per cent chance of the donor's death. It is a major operation where usually the left lobe of the liver along with the veins is transplanted.

"The death in this case can be due to complications after the surgery, such as infection or leakage of some vessels,'' said an expert who didn't want to be named.

While the treating surgeon was not available for comment, Apollo confirmed that the donor died in their hospital. ''It was the 25th successful surgery in the hospital. The death could have occurred due to pulmonary embolism, a clot developed in the pulmonary vein,'' said Dr Anupam Sibal, medical director of Indraprastha Apollo.

The hospital said Subash was a relative of Srikant and an authorisation committee had verified the facts. According to Transplantation of Human Organs Act 1994 and other laws on organ donation in the country, ''the donor can be the first degree relative, spouse or exception unrelated on the basis of love and affection and without any monetary transaction''.

[Non-text portions of this message have been removed]

Lib- Medical Ethics file
Sw

JH
28/7

MP-2

Main Identity

From: "bioethics" <bioethics@aku.edu>
To: "Bioethics Listserv" <bioethics@aku.edu>
Cc: "bioethics" <bioethics@aku.edu>
Sent: Monday, September 29, 2003 4:46 PM
Subject: [southasianmedicalethics] Sex Selection for Social Reasons: Religiousand Moral Perspectives

Email: <mailto:bioethics@aku.edu> bioethics@aku.edu;
<mailto:amyn.majeedlassi@aku.edu> amyn.majeedlassi@aku.edu
Website: <http://www.aku.edu/bioethics/index.htm> www.aku.edu/bioethics

Official: Yes

Public release date: 24-Sep-2003

Contact: Brent Waters
rct@sris.info

412-585-0842
Science and Religion Information Service

SEX SELECTION FOR SOCIAL REASONS: RELIGIOUS AND MORAL PERSPECTIVES

Two reports in the 25 September 2003 issue of Human Reproduction suggest that the coming availability of sex selection technology is not likely to skew the balance between the sexes. Two experts in religion and reproductive technology respond to this report and to the way it might be used in the ethics and public policy debate over the availability of sex selection technology.

All quotes are free to use by journalists in any news medium. Contact information is provided and follow-up interviews are encouraged.

1. Statement by Karen Lebacqz, Ph.D., an expert in religious and feminist bioethics and professor, Pacific School of Religion, Berkeley, CA. "According to this survey, allowing sex selection in Germany and in the UK would be unlikely to skew the 'gender' balance. Authors mean the 'sex' balance, since the issue is biological sex at birth, not gender. Gender is a learned social position. One can be born female but grow up to live and work as a man. One can be born male but grow up to live and work as a woman. "Thus, the first questions that come to my mind in response to this announcement are: why do we equate sex with gender, and why do we fear a gender imbalance? Many societies experience times when there is an imbalance in biological sexes, and they make interesting adaptations. They may permit polygamy, raise a 'male' child into a female role, encourage or at least not punish same-sex partnerships, etc. There is nothing intrinsically wrong with having an imbalance of biological sex in a society. Why, then, is it such an issue?

"The answer is surely because we presume that a great imbalance in sex distribution will correlate with an imbalance in social power as well. For example, what if the results of this survey were different? What if

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75% of respondents in one or both places wanted a girl child first? Or wanted girl children exclusively, and would use the technology to ensure their preferences? Would there then be great public resistance? I suspect so! But would the resistance be based on a fear of sex 'imbalance' or would it be based on a resistance to women taking over the world?

"Finally, we must ask why people would not use technology when they have a strong desire to have "one of each." Suppose the first child is a boy. If, as was strongly the case in the UK, they then want a girl, why not use technology to get this result? The rather strong resistance to the use of technology (or was it to the money needed to secure it?!) suggests that many people think there is something intrinsically wrong with using technology to satisfy our desires for children of a particular sex. Perhaps it is one of the few places of 'wonder' left in our world and we are wise to resist controlling every aspect of human life."

2. Statement by Brent Waters, D.Phil., author of "Reproductive Technology: Toward a Theology of Procreative Stewardship." Director, The Jerre L. and Mary Joy Center for Ethics and Values and Associate Professor of Christian Social Ethics at Garrett-Evangelical Theological Seminary, Evanston, IL. "The conclusion of the report presumably reassures us that we need not worry about sex selection techniques because the ill-effect of skewing gender balance will not occur. The majority of parents do not intend to use this technology--at least not in Germany and the United Kingdom.

"There are two reasons, however, why we should be skeptical about this reassuring conclusion. First, we do not know how parents would respond outside of these two European cultures. Whether gender balance becomes skewed if sex selection techniques were readily available in cultures placing a higher value on one sex or the other remains an open question. This is especially the case in regimes attempting to restrict population growth.

"Second, gender balance is not the only ethical issue at stake. It is simply assumed that selecting the sex of offspring is a matter of preference and not morality. Yet it is at least arguable that parenthood is characterized by the unconditional rather than conditional acceptance of children, a quality that is clearly eroded by the availability of sex selection technology. The way the research for this report was conducted merely reinforces the growing perception of children as commodities satisfying the
desires of their parents.

"Sex selection technology is but one more tool for developing a market in desirable children. The most promising aspect of this report is the fact that most respondents have no intention of using sex selection techniques, reflecting, I believe, a moral intuition that there is something inherently wrong with the process itself. That is a healthy perception that needs to be reinforced through laws and policies governing the availability and use of selection technology."

MP-2

Main Identity

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Cc: "amyn.majeedlassi" <amyn.majeedlassi@aku.edu>
Sent: Tuesday, September 02, 2003 6:27 PM
Subject: [southasianmedicalethics] Proceedings of 2nd Symposium & Workshop onEthical Issues in Health Research

SECOND SYMPOSIUM AND WORKSHOP
ON ETHICAL ISSUES IN HEALTH RESEARCH IN DEVELOPING COUNTRIES
Held on: August 14-18, 2003, Aga Khan University, Karachi, Pakistan.

Report, Presentations & Group Photograph are available on the
AKU Bioethics Initiatives website
http://www.aku.edu/bioethics

To view the Report, Presentations and Group Photograph please click
here:
http://www.aku.edu/bioethics/newsandevents.shtm

Best regards,

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Official: Yes

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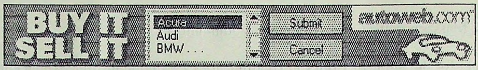

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- ☐ **Health Ethics** Centre

Science: Biology: Biomedical **Ethics**: Institutes

- ☐ Pope John Center for the Study of **Ethics** in **Health** Care - a Catholic institute which engages in research, education, and publication in biomedical **ethics**.
- ☐ University of Buffalo Center for Clinical **Ethics** and Humanities in **Health** Care

Science: Biology: Biomedical **Ethics**

- ☐ National Consultative **Ethics** Committee for **Health** and Life Sciences (France) - contains all the opinions, recommendations, and reports, in French and English, on ethical problems raised by progress in the fields of biology, medicine, and **health**, published since the committee's establishment.
- ☐ Issues in **Health** Care - discussing issues in medical **ethics** such as euthanasia, HIV disclosure, and others.
- ☐ Medical **Ethics**: Where Do You Draw the Line? - new developments in medicine and **health** care raise many ethical questions. Learn about current research and explore your own beliefs about these controversial issues.

Society and Culture: Religion and Spirituality: Faiths and Practices: Christianity: Denominations and Sects: Catholic: Education: Organizations

- ☐ Pope John Center for the Study of **Ethics** in **Health** Care - a Catholic institute which engages in research, education, and publication in biomedical **ethics**.

Arts: Humanities: Medical Humanities

- ☐ University of Buffalo Center for Clinical **Ethics** and Humanities in **Health** Care

Business and Economy: Companies: **Health**: Software: Medical

- ☐ Doctor's Dilemma, Essentials of Medical **Ethics** Bioethics - interactive role-playing program that allows the user to explore his or her own approach to medical **ethics**.

Regional: Countries: France: Science

- ☐ National Consultative **Ethics** Committee for **Health** and Life Sciences (CCNE) - contains all the opinions, recommendations, and reports, in French and English, on ethical problems raised by progress in the fields of biology, medicine, and **health**, published since the committee's establishment.

Regional: U.S. States: Massachusetts: Cities: Braintree: Community

- ☐ Pope John Center for the Study of **Ethics** in **Health** Care - a Catholic institute which engages in research, education, and publication in biomedical **ethics**.
- ☐ Pope John Center for the Study of **Ethics** in **Health** Care - a Catholic institute which engages in research, education, and publication in biomedical **ethics**.

Regional: U.S. States: New York: Cities: Buffalo: Education: College and University: Public: SUNY Buffalo: Departments and Programs

- ☐ Center for Clinical **Ethics** and Humanities in **Health** Care

Net Events: **Health**: Chat Rooms

- ☐ Current Events in **Health** - discuss all current events related to **health** and fitness such as **ethics in** medicine, the latest medical findings and more.
- ☐ Basic **Ethics** in Experimental Studies - channel #biomedicina. Chat in Spanish.

Health: **Health** Care: Policy: Journals

- ☐ Journal of **Health** Politics, Policy and Law - original scholarship on **health** politics, policy, and law from areas such as political science, economics, history, sociology, **health** services research, philosophy, **ethics**, and so forth

Government: Law: **Health**: Organizations

- ☐ American Society of Law, Medicine and **Ethics** (ASLME)

Health: Procedures and Therapies: Organ Transplants: Xenotransplantation

- ☐ **Ethics** of Xenografting: Transplanting Animal Organs into Humans

Health: Reproductive **Health**: Abortion

- ☐ Abortion and Reproductive Rights: Medicine, **Ethics**, and the Law

Health: Reproductive **Health**: Preimplantation Genetic Diagnosis

- ☐ **Ethics** and Regulation of PGD in Germany

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HS Pl. put this in a Resource file on Public Health Ethics

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13/7/98

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1 of 57

TI: Moral tensions and obligations of occupational therapy practitioners providing home care.
AU: Opacich-KJ
AD: University of Illinois, School of Public Health, Chicago, USA.
SO: Am-J-Occup-Ther. 1997 Jun; 51(6): 430-5
This source is Available only few issues in S.J.M.C. Library
LA: ENGLISH
AB: Home care has been valued as a relevant context for the provision of occupational therapy since the inception of the field. The setting provides rich opportunities to restore meaningfulness in living for clients whose lives have been disrupted by illness or untoward events. Additionally the home care setting allows practitioners to exercise professional commitments and to meet ethical obligations congruent with the field of occupational therapy. Nevertheless, the home care arena is not exempt from the pressures that pervade the health care industry. To thrive in the provision of home care, occupational therapy practitioners must prepare themselves to deal with the philosophic, economic, and moral challenges inherent in the setting. This article explores the moral obligations of occupational therapy practitioners who provide home care. More specifically, it addresses obligations to self, to patients, to caregivers, to society, to the profession, to fellow health care providers, and to agencies and payers. Ethical principles associated with each are highlighted, and issues are raised. Home care practitioners who are attuned to the moral commitments imbedded in occupational therapy philosophy will most likely incorporate these tenets into their clinical decisions.

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TI: [Quality in public health. Deficits, concepts and political quality key issues from the ministerial viewpoint]
AU: Ruprecht-TM
AD: Behorde fur Arbeit, Gesundheit und Soziales Hamburg.
SO: Z-Arztl-Fortbild-Qualitatssich. 1997 Feb; 91(1): 75-81
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH
AB: To preserve the quality of the German health care system as well as continuously optimize it towards the needs stated by ethics and law, an inter-professional and inter-institutional quality policy is required. It should be patient-centered, focus on process management and be based on EN ISO-Standards adapted to the specific needs of health care. The latter could provide internationally compatible models for quality management and quality improvement including economic efficiency. The 40 nation Council of Europe's 5th European Conference of Health Ministers in Warsaw as well as the 69th Conference of German Federal State Health Ministers (GMK) at Cottbus, who tackled the issue in November 1996, pointed out essential aspects. The GMK stated a lack of effective general concepts, quality control and patients' rights protection in Germany. Both conferences demanded equity, social justice and an active participation of patients in the setting of quality standards and the conception, functioning and control of health care. This includes rationalisations by using the limited funds in a most effective way.

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TI: Is research into ethnicity and health racist, unsound, or important science? [see comments]

AU: Bhopal-R
AD: Department of Epidemiology and Public Health, University of Newcastle. rbhopal@sph.unc.edu
SO: BMJ. 1997 Jun 14; 314(7096): 1751-6
This source is Available in S.J.M.C Library
Call Number: From 1914+
LA: ENGLISH
AB: Much historical research on race, intelligence, and health was racist, unethical, and ineffective. The concepts of race and ethnicity are difficult to define but continue to be applied to the study of the health of immigrant and ethnic minority groups in the hope of advancing understanding of causes of disease. While a morass of associations has been generated, race and ethnicity in health research have seldom given fundamental new understanding of disease. Most such research is "black box epidemiology." Researchers have not overcome the many conceptual and technical problems of research into ethnicity and health. By emphasising the negative aspects of the health of ethnic minority groups, research may have damaged their social standing and deflected attention from their health priorities. Unless researchers recognise the difficulties with research into ethnicity and health and correct its weaknesses, 20th century research in this subject may suffer the same ignominious fate as that of race science in the 19th century.

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TI: Screening and the new genetics [letter]
AU: Cooper-JD; Franks-AJ
SO: J-Public-Health-Med. 1997 Mar; 19(1): 121
this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: [Epidemiology and public health--useful tool or a problem?]
AU: Nordhagen-R; Forde-R
AD: Avdeling for samfunnsmedisin, Statens institutt for folkehelse, Oslo.
SO: Tidsskr-Nor-Laegeforen. 1997 May 10; 117(12): 1799-803
this source is not Available in S.J.M.C.Library
LA: NORWEGIAN; NON-ENGLISH

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TI: Preparing physicians for practice in managed care environments.
AU: Lurie-N
AD: University of Minnesota Schools of Medicine and Public Health, Minneapolis, USA. lurie001@maroon.tc.umn.edu
SO: Acad-Med. 1996 Oct; 71(10): 1044-9
This source is Available in S.J.M.C Library
LA: ENGLISH
AB: The author first describes the evolution and characteristics of managed care and its emphasis on the care of populations as well as individuals. She then reviews managed care's implications for medical education; for example, managed care physicians must know non-office-based approaches to keeping their patients healthy. She identifies and defines eight domains of knowledge in which physicians must be competent for practice in environments dominated by managed care. These are epidemiologic thinking, human behavior, organizational behavior, information systems, quality measurement and improvement, health system financing and delivery, ethics, and systems based care. Teaching students to practice in managed care environments is a challenge partly because there are few role models of the new breed of physician among medical school faculties. The author suggests strategies and attitudes to remedy this situation (for example, faculty must understand that managed care is not homogeneous and that it is not all bad; medical schools should develop "master teachers" for the rest of the faculty; and interactive CD-ROM-driven problem-based learning sets could be used). Focusing on training faculty for

the new era and on emphasizing the eight knowledge better physicians, whether they practice inside or outside managed care.

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TI: Law and medicine.
AU: Gostin-LO
AD: Georgetown/Johns Hopkins University Program on Law and Public Health, Washington, DC, USA.
SO: JAMA. 1997 Jun 18; 277(23): 1866-7
This source is Available in S.J.M.C Library
Call Number: From: 1918+
LA: ENGLISH

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TI: Ethical and legal issues associated with substance abuse by pregnant and parenting women.
AU: Garcia-S
AD: University of South Florida, Tampa 33620, USA.
SO: J-Psychoactive-Drugs. 1997 Jan-Mar; 29(1): 101-11
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The many pressing medical, psychological, legal, and ethical problems associated with substance abuse by pregnant and parenting women present daunting challenges. One approach is to adopt a legal perspective where the rights of mothers, fetuses, and children are pitted against one another in courtrooms and state legislatures. Another approach is to embrace a public health perspective, characterized by treating pregnant and postpartum substance abusers, protecting at-risk fetuses and children, and strengthening broken families. Both ethical concepts and legal tenets must be considered to develop new paradigms designed to help at-risk mothers and children and to protect the rights claimed by all involved.

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TI: Alcohol, the individual and society: what history teaches us.
AU: Room-R
AD: Addiction Research Foundation, Toronto, Canada.
SO: Addiction. 1997 Mar; 92 Suppl 1: S7-11
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Drinkers derive both pleasure and pain from drinking, but harm may come also to others. Through religious or secular rules, societies have sought to limit these "externalities" of drinking. Societal reactions have primarily focused on social harms from drinking; policy attention to casualties and chronic health effects is fairly recent. Drinking behaviour varies greatly according to the cultural framing of alcohol; societal policies tend to vary accordingly. Ecological constraints and social norms on preparation and use meant that alcohol was often available only sporadically in tribal and village societies. Alcohol production has been increasingly industrialized and marketing increasingly globalized in the modern era. Now, free trade agreements and the doctrine of consumer sovereignty increasingly limit the scope of national alcohol control policies. On the other hand, modern society demands exacting standards of attention and care incompatible with intoxication, for instance when driving a car or minding children. Managing the conflict between these and alcohol's ready availability is seen as a wholly individual rather than a societal responsibility. Those who fail the task are defined as alcoholics, and modern states have increasingly provided treatment for them. While there is a renewed public health concern about the externalities of drinking, substantial availability reductions have historically often required the mobilization of strong popular movements of remoralization.

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TI: Confidentiality versus disclosure of a patient's infectious status.
AU: Nicol-TE
SO: Gen-Dent. 1997 Jan-Feb; 45(1): 78-80
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Patients in health care settings have a legal and moral right to privacy, which includes confidentiality of all information related to the patient or gathered by the patient's health care team. Even so, the right to privacy is not total. Under certain circumstances, that right must yield to a state's fundamental right to enact laws to promote public health and to ensure public safety and welfare. Justifiably, dental health care team members are concerned with their health and with the possibility of being infected by a fatal disease such as acquired immunodeficiency syndrome (AIDS). The right to know patients' infectious status is growing with the mortality rate of the disease. However, as more health care workers learn of a patient's infectious status, that patient's privacy diminishes. Abiding by laws that enforce doctor-patient confidentiality while still fulfilling their obligations to their staffs and related third parties often proves difficult for dentists and physicians. Since the discovery of AIDS, believed to be caused by the human immunodeficiency virus (HIV), health care providers have been increasingly conscientious in maintaining these professional relationships.

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TI: Domestic violence identification and referral.
AU: Gibson-Howell-JC
AD: Department of Periodontics, West Virginia University School of Dentistry, Morgantown, USA.
SO: J-Dent-Hyg. 1996 Mar-Apr; 70(2): 74-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This report reviews the dental, medical, nursing, and public health literature concerning domestic violence prevalence, morbidity, mortality, education, and legislation. The primary goal of this report is to increase awareness of the signs of suspected domestic violence and the importance of being involved in prevention and early intervention. A second goal of this report is to increase awareness of domestic violence and to encourage the dental hygiene community to investigate methods to intervene and prevent this increasing problem. For dental hygienists, the commitment to learn and to help others should drive the initiative to address this concern for the well being of society. Due to the nature of domestic violence and our tendency to avoid involvement in the personal lives of others, this issue may be difficult for some people to encounter. It is through professional and continuing education that we strive to be better informed and equipped to venture effectively into this arena. Lastly, we are obligated to adhere to the commitment of the Dental Hygiene Code of Ethics by promoting public public health and safety for all in the community, the nation, and the world.

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TI: Commentary: don't forget the plumber: research in remote Aboriginal communities [comment]
AU: Miller-P; Rainow-S
AD: Nganampa Health Council, Alice Springs, NT.
SO: Aust-N-Z-J-Public-Health. 1997 Feb; 21(1): 96-7
this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: Hepatitis C and policy implementation: ethics as a dialogic process for resource allocation [editorial]
AU: Hepworth-J; Krug-G
SO: Aust-N-Z-J-Public-Health. 1997 Feb; 21(1): 4-7

this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: [Genetics and society: ethic and legal implications]
AU: Mattei-JF; Rauch-C
AD: Departement de genetique medicale, Hopital d'Enfants de la Timone, Marseille.
SO: Rev-Prat. 1997 Jan 15; 47(2): 182-6
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH
AB: Medical genetics, recently individualised as a full medical specialty, evidences new problems issued from its natural and historical developments. Genetics counselling, prenatal and predictive diagnosis may be considered as a real progress when applied in the strictly medical and individual fields. When extended to the whole community to answer collective choices, these technologies can turn into eugenic and standardizing practices. Regarding the public health and the economic necessity it could be inviting to overpass the essential values on which are founded our humanity. In that context laws are required to defend the best use for human being several practices, but only after an ethical debate in which everyone should participate.

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TI: Ethical decision making for children.
AU: Savage-TA
AD: Department of Public Health, Mental Health, and Administrative Nursing, University of Illinois at Chicago College of Nursing, Illinois, USA.
SO: Crit-Care-Nurs-Clin-North-Am. 1997 Mar; 9(1): 97-105
this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: Positive toxicology screening in newborns: ethical issues in the decision to legally intervene.
AU: Burns-DL
AD: George Mason University, College of Nursing and Health Science, Fairfax, VA, USA.
SO: Pediatr-Nurs. 1997 Jan-Feb; 23(1): 73-5; discussion 76-8, 86
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Perinatal substance abuse causes a host of problems including physical and psychological impairments to a developing fetus. However, responding to the needs of pregnant women who use drugs and their children poses an additional challenge in this already deplorable situation. Foster care, adoption, criminalization, and reunification are all possibilities as intervention options in this dilemma. Each of these options prompts additional problems for mother, child, and provider. What was once uncommon or uncontroversial for public health nursing is now bringing a new wave of discussions in the health system and nurses need to be cognizant of the ramifications of delivering care to perinatal substance abusing mothers and their families. Assessment, planning, intervention, and evaluation--the nursing process--emerges as an invaluable tool.

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TI: Communication with the cancer patient in China.
AU: Li-S; Chou-JL
AD: Shanghai Cancer Institute, China.
SO: Ann-N-Y-Acad-Sci. 1997 Feb 20; 809: 243-8
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1946-1980
LA: ENGLISH

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TI: [Management of prenatal diagnosis of trisomy 21 for women with increased risk. An approach of public health]
AU: Manuel-C; Auquier-P; Devictor-B; Simeoni-MC
AD: Laboratoire de Sante publique, Faculte de Medecine, Marseille.
SO: Presse-Med. 1997 Mar 15; 26(8): 373-7
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH

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TI: The health of prisoners and the two faces of Benthamism.
AU: Wiener-MJ
SO: Clio-Med. 1995; 34: 44-58
this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: Conflicts of interest: conceptual and normative issues [see comments]
AU: Pritchard-MS
AD: Center for the Study of Ethics in Society, Western Michigan University, Kalamazoo 49008-3899, USA. pritchard@wmich.edu
SO: Acad-Med. 1996 Dec; 71(12): 1305-13
This source is Available in S.J.M.C Library
LA: ENGLISH
AB: Growing university-industry ties, particularly in biomedical areas, naturally raise concerns about conflicts of interest. Such conflicts are essentially problems in business and professional ethics. As of the fall of 1995, all institutions seeking funding from either the Public Health Service or the National Science Foundation have been required to maintain and enforce a written policy on conflicts of interest. The PHS and the NSF also require the disclosure of "significant" financial interests that might affect the research. Although the PHS and NSF requirements may prove helpful, they are not sufficient for monitoring the full range of serious conflicts of interest that can arise in university-industry relations. The PHS and the NSF are basically concerned with potential bias in the design, conduct, and reporting of research. Their disclosure requirements are restricted to financial considerations of $10,000 or more. However, bias in research can result from conflicts of interest when much less is at stake financially. Furthermore, it can arise at both individual and institutional levels. This article attempts to provide a conceptual and normative analysis of conflicts of interest that better enables us to understand the subtleties that can be involved. This article is one of three in this issue of Academic Medicine that deal with issues of conflict of interest in university-industry research relationships. These articles are discussed in an overview that precedes them.

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TI: Ethics issues in academic-industry relationships in the life sciences: the continuing debate [see comments]
AU: Blumenthal-D
AD: Harvard Medical School, Boston, Massachusetts, USA.
SO: Acad-Med. 1996 Dec; 71(12): 1291-6
This source is Available in S.J.M.C Library
LA: ENGLISH
AB: The author reviews in detail the status of academic-industry relationships (AIRs) in the life sciences from both ethical and empirical perspectives, and identifies ethical issues that have been resolved and those that must still be debated. He summarizes by stating that ethical reasoning militates against the involvement of scientists and universities in those AIRs in which a financial conflict of interest on the part of life science investigators may affect the welfare of human subjects and trainees. Even in other types of AIRs, conflicts

of interest have effects on professional decision making that could damage the integrity and productivity of life sciences research, especially scientists' withholding of data and their redirecting of research in more commercial directions. These effects could also help undermine public trust in and support of university researchers. Balanced against these worrisome effects are the benefits of AIRs in increasing some investigators' creativity and productivity, in encouraging technology transfer, and thus in promoting economic growth and public health. He concludes that more research is needed on the harms and benefits of AIRs, especially the development of better data on the effects of withholding data, and also on the economic and health benefits of AIRs and public attitudes toward issues of scientific research that involve possible conflicts of interest. More information on these questions would allow policymakers to make more realistic estimates of the gains and losses associated with AIRs. In the meantime, current information suggests that in general the conflicts of interest created by AIRs are real, consequential, but tolerable if managed carefully. Until more is known about the effects of AIRs, it is prudent for universities and faculty to participate at modest levels in such relationships and to monitor them carefully. This article is one of three in this issue of Academic Medicine that deal with issues of conflict of interest in university-industry research relationships. These articles are discussed in an overview that precedes them.

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TI: [Healthy life style. Perspectives of prevention in modern society]
AU: Raspe-H
AD: Institut fur Sozialmedizin, Medizinische Universitat zu Lubeck.
SO: Z-Arztl-Fortbild-Jena. 1997 Jan; 90(8): 741-6
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH
AB: Clinical prevention is defined as the application of all individual practice contacts of patients and physicians during the screening after risky habits or living conditions for the following specific consultation (i.e., aiming for "free of tobacco") and/or induction of specific interventions (i.e., medical check-up, health examination, immunization). All data available up to now are demonstrating that the theoretically accessible options for clinical prevention are realized merely imperfectly by physicians and/or are hardly accepted by the patients. This may be due to the restricted perception and clarification of three problem areas; they are separately discussed: 1. The clinical prevention is also part of a comprehensive "prevention politic" and needs adequate general conditions. I.e., it is generally unclear, who is supposed to take care of the health promotion and prevention: the government with its public health services, the health insurances, the society of panel physicians? 2. Clinical prevention is more distant to a strict outcome orientation than other medical areas. There is a lack of a firm proof of its individual, epidemiological, cultural, and economical effects - namely the positive and negative ones. 3. (Clinical) prevention is especially exposed to ethical tensions. The protection of the patient's (or the client's) autonomy plays a particular role. If it is possible 1. to reduce the fear of physicians and patients for the political implications of clinical and medical prevention more than in the past, 2. to work out and distribute convincing empirical proofs of the desired (and undesired) effects of prevention, and 3. to discuss the ethical tensions typical of prevention as well as to reduce them in each single case, the program of clinical prevention would have a real chance in Germany. Otherwise it has to be feared that there will only be "Medical Prevention Weeks".

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TI: [Public health surveillance: historical origin, methods, and assessment]
AU: Declich-S; Carter-AO
AD: Laboratorio di Epidemiologia e Biostatistica, Istituto Superiore di Sanita, Roma.

SO: Ann-Ist-Super-Sanita. 1996; 32(3): 317-37
this source is not Available in S.J.M.C.Library
LA: ITALIAN; NON-ENGLISH
AB: In the last three decades disease surveillance has grown into a complete discipline, quite distinct from epidemiology. This expansion into a separate scientific area within public health has not been accompanied by parallel growth in the literature about its principles and methods. The development of the fundamental concepts of surveillance systems provides a basis on which to build a better understanding of the subject. In addition, the concepts have practical value as they can be used in designing new systems as well as understanding or evaluating currently operating systems. This article reviews the principles of surveillance, beginning with an historical survey of the roots and evolution of surveillance, and discusses the goals of the public health surveillance. Methods for data collection, data analysis, interpretation, and dissemination are then presented, together with proposed procedures for evaluating and improving a surveillance system. Finally, some points to be considered in establishing a new surveillance system are presented.

24 of 57

TI: "Socialized medicine," resource allocation and two-tiered health care--the Danish experience.
AU: Holm-S
AD: Department of Medical Philosophy and Clinical Theory, Faculty of Health Sciences, University of Copenhagen, Denmark.
SO: J-Med-Philos. 1995 Dec; 20(6): 631-7
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This paper describes the present resource allocation problems in the Danish tax-based public health care system and presents an analysis of the two policy options put forward as a solution to these problems: (1) explicit rationing of services, and (2) the introduction of two-tiered health care. It is argued that a two-tiered system with a private second tier is unlikely to be acceptable and viable in Denmark, whereas an introduction of a second tier within the public system may be more acceptable. It is further argued that present implicit rationing methods may be unethical and ought to be replaced by explicit rationing.

25 of 57

TI: Confidentiality and the AMA's new code of ethics: an imprudent formulation? [letter]
AU: Komesaroff-PA
SO: Med-J-Aust. 1997 Feb 17; 166(4): 221
This source is Available in S.J.M.C Library
Call Number: From: 1966+
LA: ENGLISH

26 of 57

TI: The two cultures and the health care revolution. Commerce and professionalism in medical care [see comments]
AU: McArthur-JH; Moore-FD
AD: Harvard Business School, Boston, MA, USA.
SO: JAMA. 1997 Mar 26; 277(12): 985-9
This source is Available in S.J.M.C Library
Call Number: From: 1918+
LA: ENGLISH
AB: The current trend toward the invasion of commerce into medical care, an arena formerly under the exclusive purview of physicians, is seen by the authors as an epic clash of cultures between commercial and professional traditions in the United States. Both have contributed to US society for centuries; both have much to offer in strengthening medical care and reducing

costs. At the same time, this invasion by commercialism of an arena formerly governed by professionalism poses severe hazards to the care of the sick and the welfare of communities: the health of the public and the <u>public health</u>. Some of these hazards are briefly listed and reviewed, together with a brief outline of standards that might be established nationally to abate these hazards. A national agency in the private sector is proposed, the National Council on Medical Care, to set standards and provide an approval mechanism that would then be the basis for state enforcement through licensing. Two models for such an initiative are outlined, one based on the National Academy of Sciences as the initiating force, and the other on an initiative provided by a consortium of national charitable foundations interested in health policy. In both cases, wide support from the national foundations would be essential. In the case of the academy model, some government funds might also be available without loss of the freedom of a private-sector initiative. Some operational options for such a national council, its membership, and the conduct of its affairs are briefly outlined as a basis for further discussion.

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TI: Not just for breakfast anymore [news]
AU: Hanson-MJ
SO: Hastings-Cent-Rep. 1997 Jan-Feb; 27(1): 49
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

28 of 57

TI: QALYS and <u>ethics</u>: a health economist's perspective.
AU: Williams-A
AD: Centre for Health Economics, University of York, UK.
SO: Soc-Sci-Med. 1996 Dec; 43(12): 1795-804
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH
AB: Objectors on ethical grounds to the use of QALYs in priority-setting in <u>public health</u> care systems are here categorised as (1) those who reject all collective priority-setting as unethical; (2) those who accept the need for collective priority-setting but believe that it is contrary to medical <u>ethics</u>; (3) those who accept the need for collective priority-setting and do not believe that it is contrary to medical <u>ethics</u>, but reject the role of QALYs in it on other ethical grounds; and (4) those who accept the need for collective priority-setting in principle, but are unwilling to specify how it should be done in practice. It is argued that the first two groups of objectors are simply wrong, if distributive justice is a proper ethical concern in this context. The third group is of more interest, as this group appears to believe that QALYs are unethical because it is unethical to regard QALY maximisation as the sole objective of the health care system. This paper argues that QALYs are relevant to a much wider range of objectives than QALY maximisation, and that they can accommodate a wide variety of health dimensions and sources of valuation. They can also accommodate the differential weighting of benefits according to who gets them, so they do not commit their users to any particular notion of distributive justice. What they do commit their users to is the notion that the health of people is a central concept in priority-setting, and that it is desirable, for reasons of accountability, to have the bases for such priority-setting made as precise and explicit as possible. The fourth group of objectors needs to acknowledge that there is no perfect system on offer, and since priority-setting does and will proceed willy-nilly we cannot wait until there is. It would be more constructive to set up the desiderata that a priority-setting system should ideally fulfil, and then appraise all feasible alternatives (including the status quo) even-handedly by those criteria. None will be perfect, but this author predicts that QALYs would emerge from such an appraisal with a significant role to play.

29 of 57

TI: The consequences of knowing: ethical and legal liabilities in illicit drug research.
AU: Fitzgerald-J; Hamilton-M
AD: Department of Public Health & Community Medicine, University of Melbourne, Parkville, Australia.
SO: Soc-Sci-Med. 1996 Dec; 43(11): 1591-600
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Ethnographic research into illicit drug use necessarily involves the researcher being aware of illegal activities. Information about illegal activities is obtained through the establishment of confidential relationships with research participants; however there are legal and ethical obligations on researchers to breach confidential relationships formed in the research environment. The recent suspension of a research project by an Institutional Ethics Committee serves to illustrate some of the processes that form the research process, shape the boundaries to legitimate knowledge and some of the consequences of knowing about illegal activities.

30 of 57

TI: [Ethical issues in public health activity with special emphasis on nonclinical biomedical study]
AU: Inaba-Y
SO: Nippon-Koshu-Eisei-Zasshi. 1996 Oct; 43(10): 879-81
this source is not Available in S.J.M.C.Library
LA: JAPANESE; NON-ENGLISH

31 of 57

TI: Public confidence in public health research ethics [comment]
AU: Mariner-WK
AD: Boston University Schools of Public Health and Medicine, MA, USA.
SO: Public-Health-Rep. 1997 Jan-Feb; 112(1): 33-6
This source is Available only few issues in S.J.M.C. Library
Call Number: From:1949-1984
LA: ENGLISH

32 of 57

TI: Ethical awareness in practice.
AU: MacPhail-S
AD: Bioethics Centre, University of Alberta.
SO: AARN-News-Lett. 1996 Dec; 52(11): 8
this source is not Available in S.J.M.C.Library
LA: ENGLISH

33 of 57

TI: [Current legislation in public health--an example for post-modern social ethics?]
AU: Rothfuss-J; Adam-H
AD: Abteilung fur Innere Medizin, Medizinische Hochschule Hannover.
SO: Gesundheitswesen. 1996 Oct; 58(10): 505-9
this source is not Available in S.J.M.C.Library
LA: GERMAN; NON-ENGLISH
AB: Social ethics of affirmative postmodernists are discussed in relation to recent German health care legislation. It could be shown that: 1. the health care legislation 1989 and 1993 only partially fulfills the postmodern call for "cultivation of individual responsibility", 2. both laws largely fail to enforce the principle of subsidiarity, and 3. postmodernist thinking is weak on the question of global strategies but strong in the area of individualism and subjectivity. We conclude that postmodern social ethics are useful to compensate areas largely neglected by recent German health care legislation, rather than that the legislation is an example of postmodern social ethics.

34 of 57

TI: Standards of care and ethical concerns in genetic testing and screening.
AU: Parker-LS; Majeske-RA
AD: Department of Human Genetics, University of Pittsburgh, Graduate School of Public Health, PA 15261, USA.
SO: Clin-Obstet-Gynecol. 1996 Dec; 39(4): 873-84
This source is Available in S.J.M.C Library
Call Number: From: 1959+
LA: ENGLISH

35 of 57

TI: From genes to public health: the applications of genetic technology in disease prevention. Genetics Working Group [see comments]
AU: Khoury-MJ
AD: Birth Defects and Genetics Diseases Branch, Centers for Disease Control and Prevention, Atlanta, GA 30341-3724, USA.
SO: Am-J-Public-Health. 1996 Dec; 86(12): 1717-22
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH
AB: OBJECTIVES: With advances in the Human Genome Project, the implications of genetic technology in disease prevention should be assessed. METHODS: The paradigm suggested in The Future of Public Health--assessment, policy development, and assurance--was used to examine the continuum from genetic technology to public health practice. RESULTS: First, important public health functions are to (1) assess the impact of genes and their interactions with modifiable disease risk factors on the health status of the population and (2) assess the impact and safety of genetic testing on the population. Second, given the many implications of genetic testing, the public health community should participate in policy development related to the timing and use of genetic testing in disease prevention. Third, whenever appropriate, the public health community needs to ensure the development of public health genetics programs (e.g. newborn screening) and evaluate the quality and effectiveness of the use of genetic testing in disease prevention. CONCLUSIONS: Although most current genetic tests are not ready for disease prevention, there is an important role for the public health community in translating genetic technology into disease prevention.

36 of 57

TI: CDC's first 50 years: lessons learned and relearned.
AU: Satcher-D
AD: Centers for Disease Control and Prevention, Atlanta, GA 30333, USA.
SO: Am-J-Public-Health. 1996 Dec; 86(12): 1705-8
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1942-1991
LA: ENGLISH

37 of 57

TI: Testing for human immunodeficiency virus infection among tuberculosis patients in Los Angeles.
AU: Asch-SM; London-AS; Barnes-PF; Gelberg-L
AD: Division of General Internal Medicine, Pacific Center for Health Policy and Ethics, University of Southern California School of Medicine, Los Angeles, USA.
SO: Am-J-Respir-Crit-Care-Med. 1997 Jan; 155(1): 378-81
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: To investigate patterns of testing for human immunodeficiency virus (HIV) infection in tuberculosis patients, we obtained data from the tuberculosis registry and from medical records of 500 tuberculosis patients in Los Angeles County. Sixty-three percent of tuberculosis patients were tested for HIV infection, and multivariate logistic regression analysis revealed that the

likelihood of testing was significantly higher among males, persons between 20 and 49 yr old, individuals with HIV risk factors, and patients treated by public health care providers. A minimum of 12% of the total sample, 2% of females, 2% of those outside the ages of 20 to 49, 7% of patients without recorded HIV risk factors, and 17% of patients treated by private practitioners were infected with HIV. These results suggest that health care providers, particularly private practitioners, do not follow national recommendations for universal HIV testing of tuberculosis patients. Instead, HIV testing is preferentially performed on patients perceived to be at high risk for HIV infection. Because HIV seroprevalence is at least 2 to 7% in "low-risk" groups, failure to test these patients may result in significant missed opportunities for diagnosis and treatment of HIV coinfection.

38 of 57

TI: Preparation and applications of the International Aquatic Animal Health Code and Diagnostic Manual for Aquatic Animal Diseases of the Office International des Epizooties.
AU: Hastein-T
AD: Department of Fish Health, Central Veterinary Laboratory, Oslo, Norway.
SO: Rev-Sci-Tech. 1996 Jun; 15(2): 723-31
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The Office International des Epizooties (OIE) has recently prepared an International Aquatic Animal Health Code, based on the principles set out in the corresponding OIE International Animal Health Code for terrestrial animals. The principal aim of the Code and the companion Diagnostic Manual for Aquatic Animal Diseases is to harmonise health guarantees for international trade in aquatic animals (fish, molluscs, crustaceans) and aquatic animal products, and to guide state Veterinary Services and/or other competent authorities in the preparation of appropriate health certificates. The Aquatic Animal Health Code and Manual provide detailed information on definitions, notifications, ethics in connection with certification, import risk analysis and import/export procedures. By these means, the preparation of international health certificates can be based on a uniform approach to health control in aquatic animal populations, using the standardised methods described in the Diagnostic Manual. In general, health certification under the Aquatic Animal Health Code is required only for diseases notifiable to the OIE. In addition to such notifiable diseases, however, the Code establishes a list of other significant diseases which need consideration. The listed diseases are recognised as serious transmissible diseases of socio-economic and/or public health importance, in relation to which the international trade of aquatic animals and their products poses a significant risk of transfer between countries. The current status of the Code and Manual is described in detail.

39 of 57

TI: Health as a fundamental human right.
AU: Hobdell-MH
AD: Faculty of Dentistry, University of the Western Cape, Cape Town, South Africa.
SO: Br-Dent-J. 1996 Apr 6; 180(7): 267-70
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1961-1971
LA: ENGLISH
AB: Access to health care is problematic for many people throughout the world, and the environments in which they live are often detrimental to their health. Recognising health as a human right provides a platform from which to argue for strong public health programmes.

40 of 57

TI: Ethical problems in the relationship between health and work.
AU: Berlinguer-G; Falzi-G; Figa-Talamanca-I

SO: Int-J-Health-Serv. 1996; 26(1): 147-71
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Throughout history, the relationship between employers and workers has been subject to the equilibrium of power, to legislative norms, to ethical considerations, and more recently to scientific knowledge. The authors examine the ethical conflicts that arise from the application of scientific knowledge to preventive health policies in the workplace. In particular, they discuss the ethical conflicts in the application of screening practices, in the setting of "allowable limits" of harmful work exposures, and in the right of workers to be informed about work hazards. Ethical problems are also created by conflicting interests in the protection of the environment, the health of the general public, and the health of the working population, and by conflicting interests among workers, and even within the individual worker, as in the case of "fetal protection" policies. The authors emphasize the positive use of scientific information and respect for human dignity in resolving these conflicts.

41 of 57

TI: Informed consent in human experimentation before the Nuremberg code.
AU: Vollmann-J; Winau-R
AD: Institute of the History of Medicine, Free University of Berlin.
SO: BMJ. 1996 Dec 7; 313(7070): 1445-9
This source is Available in S.J.M.C Library
Call Number: From 1914+
LA: ENGLISH
AB: The issue of ethics with respect to medical experimentation in Germany during the 1930s and 1940s was crucial at the Nuremberg trials and related trials of doctors and public health officials. Those involved in horrible crimes attempted to excuse themselves by arguing that there were no explicit rules governing medical research on human beings in Germany during the period and that research practices in Germany were not different from those in allied countries. In this context the Nuremberg code of 1947 is generally regarded as the first document to set out ethical regulations in human experimentation based on informed consent. New research, however, indicates that ethical issues of informed consent in guidelines for human experimentation were recognised as early as the nineteenth century. These guidelines shed light on the still contentious issue of when the concepts of autonomy, informed consent, and therapeutic and non-therapeutic research first emerged. This issue assumes renewed importance in the context of current attempts to assess liability and responsibility for the abuse of people in various experiments conducted since the second world war in the United States, Canada, Russia, and other nations.

42 of 57

TI: Reproductive health and blurred professional boundaries.
AU: Chavkin-W; Breitbart-V
AD: The Center for Population and Family Health, Columbia University School of Public Health, New York, USA.
SO: Womens-Health-Issues. 1996 Mar-Apr; 6(2): 89-96
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: We recognize that many of the issues raised are not simple. Our proposal calls for the same thoughtful deliberation applied in other settings to be brought to bear on reproductive health care. Some have already tried alternative approaches. In Albuquerque, New Mexico, a university hospital neonatologist and the district attorney have collaborated to create an alternative to sentencing program for women who are arrested for drug-related crimes and found to be both pregnant and drug addicted. Rather than proceed with criminal sanctions, these women are offered entry into a drug treatment program that is geared to families with young children and run by the pediatrics department. Here, the physician and the district attorney collaboratively responded in ways congruent with the professional integrity of

each. In another example in Portland, Oregon, physicians, drug treatment providers, and child protective social service representatives cooperatively defeated a legislative proposal to mandatorily test and report pregnant women for illicit drug use and, instead, formed a task force to jointly develop state policy regarding the issue. Drug use, HIV infection, child abuse, and poverty are all cause for alarm. Yet it is critical that our frustration about these difficult problems not be translated into blaming individuals for "deviance," or into short-term inadequate responses. In developing policy we should consider the impact on the legal and ethical rights and obligations of both patient and physician. For every course, we should evaluate both immediate and long-term efficacy, the consequences for the doctor-patient relationship, and the consequences for medical integrity. In the midst of the present regulatory and fiscal turmoil affecting health care, we urge physicians to be careful and deliberate in the policies they embrace and the actions they take.

43 of 57

TI: The <u>public</u> <u>health</u> basis of cancer screening: principles and ethical aspects.
AU: Miller-AB
AD: Department of Preventive Medicine and Biostatistics, University of Toronto, Ontario, Canada.
SO: Cancer-Treat-Res. 1996; 86: 1-7
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

44 of 57

TI: An ethicist's commentary on the case of the veterinarian who will not utilize the proper regimen for control of roundworms.
AU: Rollin-BE
SO: Can-Vet-J. 1996 Oct; 37(10): 585-6
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

45 of 57

TI: Model curricula in <u>public</u> <u>health</u> <u>ethics</u>.
AU: Coughlin-SS
AD: Department of Biostaristics and Epidemiology, Tulane University School of <u>Public</u> <u>Health</u> and Tropical Medicine, New Orleans, Louisiana 70112, USA.
SO: Am-J-Prev-Med. 1996 Jul-Aug; 12(4): 247-51
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH

46 of 57

TI: Remember Tuskegee: <u>public</u> <u>health</u> student knowledge of the ethical significance of the Tuskegee Syphilis Study.
AU: Coughlin-SS; Etheredge-GD; Metayer-C; Martin-SA Jr
AD: Department of Biostatistics and Epidemiology, Tulane University School of <u>Public</u> <u>Health</u>, New Orleans, Louisiana, USA.
SO: Am-J-Prev-Med. 1996 Jul-Aug; 12(4): 242-6
<u>this source is not Available in S.J.M.C.Library</u>
LA: ENGLISH
AB: The ethical problems that surrounded the Tuskegee Syphilis Study prompted widespread public criticism when they first surfaced in 1972; the Tuskegee Study remains an important case in bioethics. We recently examined <u>public</u> <u>health</u> student knowledge of the ethical significance of the Tuskegee Study as part of an <u>ethics</u> curriculum needs assessment at Tulane University. A brief questionnaire was administered to 236 graduate students currently enrolled in seven epidemiology courses. Basic demographic information was obtained along with information about degree program. A series of questions was then asked to assess student knowledge of bioethics including the ethical significance of the Tuskegee Study. Only 19% (46 of 236) of the students demonstrated knowledge of

the ethical significance of the Tuskegee Study. Knowledge of the Tuskegee Study's ethical significance was higher among students who were from the United States and those who were enrolled in the epidemiology program (P < .05). The ethical problems that surrounded the Tuskegee Study have rarely been encountered in public health. However, this important case stands as an exemplar of the potential for ethical abuses in human subjects research. Such cases ought to be highlighted in public health curricula. Medical Subject Headings (MeSH): blacks, African Americans, educational curriculum, epidemiology, ethics, public health, racism.

47 of 57

TI: Development of an ISO 9000-compatible occupational health standard--II: defining the potential benefits and open issues.
AU: Levine-SP; Dyjack-DT
AD: Department of Environmental and Industrial Health, University of Michigan School of Public Health, Ann Arbor 48109-2029, USA. SLIH@umich.edu
SO: Am-Ind-Hyg-Assoc-J. 1996 Apr; 57(4): 387-91
This source is Available only few issues in S.J.M.C. Library
Call Number: From: 1970-1975
LA: ENGLISH
AB: The International Organization for Standardization (ISO) is currently voting on a final draft of ISO 14000 Environmental Standards that follow the general philosophy of ISO 9000 product quality standards. Should the international community also consider development of an ISO 9000-14000 compatible occupational safety and health management standard (OS&HMS) or an environment, safety, and health management standard? The first paper in this series (Am. Ind. Hyg. Assoc. J. 56:599-609 [1995]) introduced this subject, reviewed the historical precedents, and identified the underlying issues. In this paper the authors identify some of the potential benefits and most critical open issues that may affect the viability of an OS&HMS at the national and international levels. Twelve potential benefits are identified in the major categories of national and international, and industrial and governmental benefits; 16 open issues are identified in the major categories of applications, ethics, cost, and international issues.

48 of 57

TI: Harmonization of clinical practice guidelines for the prevention and treatment of osteoporosis and osteopenia in Europe: a difficult challenge.
AU: Reginster-JL
AD: Bone and Cartilage Metabolism Unit, University of Liege, Belgium.
SO: Calcif-Tissue-Int. 1996; 59 Suppl 1: S24-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: Europe is a patchwork of various medical cultures and financial resources. Variations abound with respect to financing, accessibility to public health systems, health expenditures, drug registration and reimbursement, the prescription of drugs, and clinical applications, as well as the perception of osteoporosis itself. However, there are possibilities for the harmonization of medical services among the various countries within Europe. The European Agency for the Evaluation of Medicinal Products (EAEMP) is attending to the centralized or decentralized procedures for the registration of drugs. The Group for the Respect of Ethics and Excellence in Science (GREES) is investigating guidelines for drug registration as well as gathering and making available medical references. The European Foundation for Osteoporosis and Bone Diseases (EFFO) is increasing awareness of the prevalence of the disease and the need for prevention and treatment. Finally, the International Federation of Societies on Skeletal Diseases (IFSSD) is coordinating epidemiologic, clinical, and social research. There is a need for increased awareness of osteoporosis throughout Europe. Health authorities are in need of cost/benefit reports leading to the registration and reimbursement of agents. Primary care physicians need information about osteoporosis and need to become involved in

the diagnosis and science of the disease. Awareness needs to be generated among specialists; they need to be educated in the latest techniques for diagnosis and treatment. Finally, the general population needs to become aware of osteoporosis and to be encouraged to participate in the prevention and treatment of this disease. Current screening and detection in Europe is being done by densitometry. However, other techniques on the horizon include ultrasound and biochemical markers. Primary prevention, i.e., maximizing peak bone mass, includes examining the genetics of osteoporosis to determine the high-risk population and promoting reasonable physical exercise and dietary/life-style habits (e.g., increased calcium and avoidance of tobacco). Secondary prevention includes the identification of high-risk groups through risk factors, biochemical markers, and densitometry and adherence to the World Health Organization definition of osteopenia-osteoporosis (adapted to financial concerns by GREES guidelines). Other therapies include hormone replacement agents (although there are risks for cancer and concerns about durability), calcium and other inhibitors of bone resorption, physical activity, and vitamin D prophylaxis in the elderly. Treatment of established or severe osteoporosis includes drugs upon availability (inhibitors of bone resorption and stimulators of bone formation), surgery, and experimental approaches.

49 of 57

TI: The American Cancer Society's National Prostate Cancer Detection Project.
AU: Littrup-PJ
AD: Department of Radiology, Wayne State University School of Medicine, Harper Hospital, Detroit, Michigan, USA.
SO: Can-J-Oncol. 1994 Nov; 4 Suppl 1: 65-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: As a significant public health problem, prostate cancer meets nearly all the criteria for screening. While concerns about incomplete natural history, progression rates and need for better prognostic factors are valid, important social and public health issues also need consideration. If future expenditures for terminal cancer care are minimized via reductions in therapy choices or coverage, no economic benefit for prostate cancer screening should exist. Narrowly focused attempts at cost reduction could inappropriately discourage highest risk groups from participating in early detection programs, thereby eliminating the greatest potential benefit of screening. The ACS-NPCDP has demonstrated that early detection of prostate cancer produced distinct stage migration to earlier, more curable disease through optimized use of DRE, TRUS and PSA. PSA is the most objective test and detects tumors of significant biologic potential. Current cost savings are possible with improved public health education about the appropriateness of early detection in the oldest age groups or those with significant pre-existing medical conditions. Prostate cancer control perhaps requires a tailored approach of screening in high risk groups and more appropriate "case finding" in the lower risk general population. The initial combination of PSA and DRE represents an ethical and economical choice for individual patients consulting with informed physicians.

50 of 57

TI: Second, let no harm be done: an American antiimmigration dilemma.
AU: d'Oronzio-JC
AD: Columbia University School of Public Health, New Jersey, USA.
SO: Camb-Q-Healthc-Ethics. 1996 Summer; 5(3): 467-72
this source is not Available in S.J.M.C.Library
LA: ENGLISH

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TI: Stanton Glantz on snuffing tobacco research [interview by Thomasine Kushner]
AU: Glantz-S
SO: Camb-Q-Healthc-Ethics. 1996 Summer; 5(3): 415-21

this source is not Available in S.J.M.C.Library
LA: ENGLISH

52 of 57
TI: Patient access to experimental drugs and AIDS clinical trial designs: ethical issues.
AU: Schuklenk-U; Hogan-C
AD: Monash University Centre for Human Bioethics, Australia.
SO: Camb-Q-Healthc-Ethics. 1996 Summer; 5(3): 400-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH

53 of 57
TI: Review of the 1995 Food and Drug Administration/National Institutes of Health Public Forum on informed consent in clinical research conducted in emergency circumstances.
AU: Lamiell-JM; Grabenstein-JD; Vander-Hamm-DG
AD: Clinical Investigation Regulatory Office, U.S. Army Medical Department Center and School, Fort Sam Houston, TX 78234, USA.
SO: Mil-Med. 1995 Dec; 160(12): 599-603
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: We describe some of the deliberations and questions raised by the recent Food and Drug Administration/National Institutes of Health Forum on Informed Consent in Clinical Research Conducted in Emergency Circumstances. Consent will have to be waived in emergency medical research if such research is to be conducted, because it is virtually impossible to obtain meaningful informed consent in emergency circumstances. There is clearly a conflict between research subject autonomy and society's perceived need for answers about emergency medical care. Who will resolve this dilemma and how it will be resolved are important questions for modern medicine.

54 of 57
TI: Ethics and public health promotion.
AU: Nilstun-T
AD: Department of Medical Ethics, Lund University, Sweden.
SO: Epidemiol-Prev. 1994 Dec; 18(61): 200-3
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: As a goal, promotion of public health is quite uncontroversial. But attempts to modify people's lifestyles and life conditions in order to realize this goal bring up a number of ethical conflicts. One such conflict concerns the balance between autonomy and paternalism in the process of changing human behaviour. In this paper a model for analysis of such conflicts is presented and applied to assess anti-smoking policies. The model consists of two dimensions: the first specifies the relevant ethical principles, the second specifies the persons involved in or affected by such policies. My conclusion is that anti-smoking policies cannot be justified by reference to the good of the person whose right to selfdetermination is limited, but only by reference to the need to protect others from that person, i.e. prevent them from being exposed to tobacco smoke.

55 of 57
TI: Some ethical ground rules for BSE and other public health threats [comment]
AU: Hunt-G
SO: Nurs-Ethics. 1996 Sep; 3(3): 263-7
this source is not Available in S.J.M.C.Library
LA: ENGLISH

56 of 57
TI: Bovine spongiform encephalopathy (BSE): the ethics concerning decisions

about whether to continue taking a risk with this disease [see comments]
AU: Dealler-S
SO: Nurs-Ethics. 1996 Sep; 3(3): 259-62
this source is not Available in S.J.M.C.Library
LA: ENGLISH

57 of 57

TI: Women's health and end-of-life decision making [comment]
AU: Grodin-MA
AD: Law, Medicine & Ethics Program, Boston University Schools of Medicine and Public Health, Massachusetts, USA.
SO: Womens-Health-Issues. 1996 Sep-Oct; 6(5): 295-301
this source is not Available in S.J.M.C.Library
LA: ENGLISH

1 of 30

TI: Palliative medicine and HIV/AIDS.
AU: O'Neill-JF; Alexander-CS
AD: AIDS Bureau, Health Resources and Services Administration, US Public Health Service, Rockville, Maryland 20857, USA.
SO: Prim-Care. 1997 Sep; 24(3): 607-15
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: This article provides an introduction to the field of palliative medicine as it applies to the care of HIV/AIDS. Issues of pain management, end-of-life care, ethics, and bereavement are discussed with the intention of providing the primary care physician additional resources in the provision of care to patients with HIV/AIDS.

2 of 30

TI: Medicine and public health, ethics and human rights.
AU: Mann-JM
SO: Hastings-Cent-Rep. 1997 May-Jun; 27(3): 6-13
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: There is more to modern health than new scientific discoveries, the development of new technologies, or emerging or re-emerging diseases. World events and experiences, such as the AIDS epidemic and the humanitarian emergencies in Bosnia and Rwanda, have made this evident by creating new relationships among medicine, public health, ethics, and human rights. Each domain has seeped into the other, making allies of public health and human rights, pressing the need for an ethics of public health, and revealing the rights-related responsibilities of physicians and other health care workers.

3 of 30

TI: Why "underpowered" trials are not necessarily unethical.
AU: Edwards-SJ; Lilford-RJ; Braunholtz-D; Jackson-J
AD: Department of Public Health and Epidemiology, University of Birmingham Medical School, UK.
SO: Lancet. 1997 Sep 13; 350(9080): 804-7
This source is Available in S.J.M.C Library
Call Number: From: 1930+
LA: ENGLISH

4 of 30

TI: Ethics in environmental epidemiology.
AU: Rossignol-AM
AD: Department of Public Health, Oregon State University, Corvallis 97330-6406, USA.
SO: Epidemiology. 1997 Sep; 8(5): 599-601
this source is not Available in S.J.M.C.Library
LA: ENGLISH

5 of 30

TI: Informed consent in epidemiologic studies involving genetic markers.
AU: Hunter-D; Caporaso-N
AD: Department of Epidemiology, Harvard School of Public Health, Brigham & Women's Hospital, Boston, MA, USA.

SO: Epidemiology. 1997 Sep; 8(5): 596-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH

6 of 30

TI: Good performance of vaccination by education.
AU: Peltola-H
AD: Children's Hospital, University of Helsinki, Finland.
SO: Biologicals. 1997 Jun; 25(2): 237-9
this source is not Available in S.J.M.C.Library
LA: ENGLISH

7 of 30

TI: [Public health safety and transfusion organization]
AU: Vachey-L
AD: l'Agence Francaise du Sang, Paris.
SO: Bull-Acad-Natl-Med. 1997 May; 181(5): 853-61
this source is not Available in S.J.M.C.Library
LA: FRENCH; NON-ENGLISH
AB: The reform of French blood transfusion, launched in 1993, has established a control system of blood transfusion public services and blood products. This reform was implemented in accordance with Ethics regarding the use of products of human origin; while assuring autosufficiency, it favors a sparing use of blood products. Product safety is guaranteed firstly by the official blood transfusion practice guidelines which provide rules for each stage of the process, and secondly by the performance and quality controls performed prior to transfusion (registration of products, screening tests) as well as in the course of the process (quality control and assurance) or after transfusion (external product control performed by the French agency for drugs "Agence du Medicament"). The safety of products is based on a series of organisational measures for blood transfusion public services: local organization schemes, staff qualifications, computerization, implementation of an hemovigilancy system. It is the control of the whole network which is a guarantee of the final security for the patients transfused. Time is required to carry out such a large scale reform, even if much progress has already been made. The level of safety and quality reached today by French blood transfusion permits a favorable comparison between France and the other developed countries.

8 of 30

TI: Professional solidarity versus responsibility for the health of the public: is a nurses' strike morally defensible?
AU: Tabak-N; Wagner-N
AD: Department of Nursing, School of Health Professions, Tel Aviv University, Ramat Aviv, Israel.
SO: Nurs-Ethics. 1997 Jul; 4(4): 283-93
this source is not Available in S.J.M.C.Library
LA: ENGLISH
AB: The purpose of this article is to deliberate the moral and legal dilemma entailed in the weapon of the labour strike as a pressure tactic on the Israeli Finance Ministry regarding job slots, budgets and, in effect, violating the collective agreement signed by the nurses and impairing patients' treatment, as opposed to refraining from striking and suffering the heavy burden of work, the lack of trained personnel, low wages, and the inability to give patients proper, high quality treatment.

9 of 30

TI: Guidelines for managing domestic abuse when male and female partners are patients of the same physician. The Delphi Panel and the Consulting Group.
AU: Ferris-LE; Norton-PG; Dunn-EV; Gort-EH; Degani-N
AD: Department of Public Health Sciences, Faculty of Medicine, University of Toronto, Ontario, Canada.