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"Medical progress must be measured by how we treat the least of our brethren"

*Dr. Abraham Verghese, best-selling author of *My Own Country* and Director of the Center for Medical Humanities and Ethics, University of Texas Health Science Center at San Antonio, Texas, was in India to participate in a two-day conference on clinical ethics. Excerpts from an interview with C.K. Meena:*



Dr. Abraham Verghese: I think in the U.S. and perhaps in India, we've drifted so far away from the ideal that we are not even aware that there is a standard that we're supposed to adhere to.

Photo: T.A. Hafeez

Can you tell us what you discussed at the ethics conference at Vellore?

At the invitation of George Chandy, the Director of Christian Medical College, we jointly put on a Clinical Ethics Conference. As you know, ethics is a very broad subject, and our goal was to focus more narrowly on clinical ethics — ethical dilemmas that arise in patient care where the patient or family or doctor or all of them are caught between a rock and a hard place. We first discussed certain core ethical principles (autonomy of the patient, beneficence, non-maleficence, justice) and core virtues (integrity, compassion, competence, honesty, professionalism) that the medical profession holds up as the ideal. Then we discussed methods one uses to work through complex ethical dilemmas, such as parents refusing to separate Siamese twins where life-saving surgery might save one but sacrifice the other. We then spent a great deal of time hearing from our colleagues in Vellore about ethical dilemmas they encounter. It was a most stimulating and vigorous discussion.

Is it really possible to arrive at a set of ethics that cuts across geographies?

Again, as long as our focus is on clinical ethics, then what is common to all geographies is the special nature of the physician-patient relationship. It is different from, say, one's relationship with the auto mechanic or grocer. The physician has a fiduciary responsibility to his or her patient: in other words, it is a special relationship where one is holding their confidence, and it comes with certain inherent obligations to the welfare of the patient. You're not transacting business where once they pay they're done. What is also common is that in the era of technology, in the era of commercialisation of medicine and in medicine taking on corporate traits, we can often lose sight of this fundamental fact — the patient is not a customer, but a person who invests you with their trust. Of the ethical principles I mentioned now, justice is particularly difficult. How do you ensure that resources are there for everyone? How do you ration care, how do you determine who gets it and who doesn't?

You spoke earlier about "corporatisation" of medicine...

In the city where I practise — San Antonio — we have many hospitals, each of which offers cardiac catheterisation and bypass surgery and so on. Does a city of that size truly need that many centres? From the hospitals' point of view, the insurance system puts greater value in such procedures and so for a hospital to be viable, it has to offer these services and compete aggressively for the patients. One sees the same thing in India, I suspect. I am told that a city like Chennai has more CTs and MRI scanners than the whole of Canada. I don't know if that is true, but driving around one certainly gets that impression. In a health system like that of Canada or Britain where the government provides health care to its citizens, you don't see such excesses. But on the other hand you might have a long waiting period to get an MRI. Clearly, both in the U. S. and in India, the for-profit health sector focuses on the percentage of the population that can afford that kind of medicine.

How do you distinguish between what is illegal and what is unethical?

That is a great question. I think that everywhere around the world physicians are struggling with issues of "professionalism," which is the term that refers to those virtues and attributes that we subscribe to in our oaths, and in our medical council bylaws and regulations. Unfortunately, there are great temptations and great forces that invite physicians to act unprofessionally. If you are an ethical surgeon and you won't take kickbacks from the lab or radiology facility to which you send your patient, or you won't give a cut to the physician who sent you the patient, you might lose referrals from other physicians, and you might struggle to survive in practice. Now an active, respected state medical board or council could make a huge difference by investigating instances of abuse, by suspending licences, by calling for hearings. But what is equally important is that we regulate ourselves. I think in the U.S. and perhaps in India, we've drifted so far away from the ideal that we are not even aware that there is a standard that we're supposed to adhere to.

At our Clinical Ethics Conference in Vellore, we did not discuss the issue of female foeticide or infanticide because, frankly, it's illegal. There is not much to debate there, is there?

Do you think ethics is something that can be taught?

Actually it's a question that medical students ask all the time. Can virtue be taught? I always say yes, but that clinical ethics is not simply about celebrating or teaching virtues. As teachers, we can hold up the ideals. But clinical ethics is also about learning methods for sorting out ethical dilemmas where your own admirable principles or virtues are in conflict. In order to do that, you have to have a certain

body of knowledge of the legal precedents around this issue and the landmark medical ethics cases that have influenced the practice. Clinical ethics is also about understanding how society has determined a value on certain things and how it has decided to legalise, or make illegal, certain things. Where the law does not spell it out, one should find out how other medical bodies have worked this out. I think this is an ample field of exploration for a young clinician in India — to codify and clarify recurring ethical dilemmas to come up with recommendations in the context of our pluralistic and unique culture.

What stage are we in, in India, when it comes to framing ethical standards?

Clinical ethics as an academic discipline hasn't emerged as strongly as it has in the United States. That's not a condemnation; that's just a statement of fact. There have been more pressing issues to worry about, one could argue. However, I think clinical trials by multinational companies are being increasingly done in this country. It's necessary for those trials to be done with the informed consent of the patient. An "institutional review board" (IRB) has to approve the study and make sure that it's not detrimental to the patient. The moment you have clinical trials being done here — and people say it's a huge industry with lots of money to be made — there is an incentive to form more IRBs. I think these IRBs, if they are not rubber stamping, pro-forma entities, will be the nucleus of ethics committees at hospitals, and of academic departments of ethics.

The issue of informed consent is going to be a major trigger for the ethics debate in this country. Has the trial been explained to the patients in their terms, their language? Have they really understood the pros and cons? Suppose a patient has cancer and entering the trial may be the only way he can afford treatment for cancer, there is a huge incentive to enter the trial. Is that truly informed consent? These are issues that are yet to be determined and shaped by debate. It requires the media, it requires medicine, and it requires the law.

Patients in India, I am told, often, even though we want them to be autonomous, will pass the baton back to the doctor. They will say, I can't make the decision, that's why I am coming to you, doctor. It's not paternalism. It's the desire on the patient's part that you guide them.

I think organ transplant issues will continue to trigger debate on ethics and the issue of consent. Because of India's law on organ donation, you can't buy an organ from a stranger, but you can get it from your wife or brother or family. But when a wife decides to give it to her husband — I am told that it happens much more often than husbands giving it to wives — is that truly an informed decision? Is there not strong societal and cultural coercion? Can the woman afford to say no?

You must have heard the argument that discussing ethics is a luxury, we're a poor country and have other priorities...

At first blush that would seem to be an instinctive reaction. Maybe having a clinical ethics department in a medical school is a bit of a luxury. But you don't need such a department to have the debate on ethics, which should be constant and continuing. I would also argue that if we can't protect and hold sacred the physician-patient relationship, if we don't have a clear sense of what is professionalism, if we are unwilling to talk about it, then everything we do gets tainted. Medical progress must be measured not only by how many transplants we did, but how we treated the least of our brethren. □