Medical Ethics

Ethics in surgical practice: An Indian viewpoint

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It is a matter of concern that medicine all over the world is often practised without proper and strict ethical controls and monitoring. A survey of surgical opinions on ethics in Canada revealed that even though a general sensitivity for clinical ethics was present amongst the members of the national association of surgeons, there was a lack of formal education and the existence of properly constituted ethics committees for the purposes of monitoring. A large number of hospitals did not appoint consultants for education in ethics and monitoring of ethical practices.

The scenario in India is worse, with hardly any institution having functional and effective ethics committees. It is, therefore, time that greater attention is paid to this aspect of surgical practice in India. Although it may not be possible or even desirable to formulate a code of ethics that covers all eventualities, a beginning at least ought to be made. The Indian Council of Medical Research has recently conducted a nationwide survey of ethical practices as prevalent in India and has formulated guidelines for the practice of research on human studies.

Ethics has an individualized or personal component and, in the case of professionals, also involves interaction with patients, their relatives and professional colleagues. This component is best defined by three Ds—discipline (a negative trait because it involves self-denial), development (positive trait) and dedication (a healthy trait).

Unfortunately, not many professionals seem to possess these traits. Contrary to the philosophy of upholding departmental and larger institutional interests above oneself, a self-centered individualistic approach is prevalent. For the benefit of society, it is, therefore, mandatory that the ethics of sacrificing self-interest is learnt and practiced.

Professional ethics and the judgements of a surgeon should not be influenced by secondary interests such as financial gains or personal prestige and should not lead to conflicts of interest in research, education and patient care. The best strategy in dealing with such conflicts by institutions and administrators is a policy of disclosure and transparency of a review process which would minimize conflict-raising activities.

Like personal ethics, the professional ethics of a surgeon also have three important components—conduct in surgical practice, surgical teaching and training, and surgical research.

ETHICS IN SURGICAL PRACTICE

Every patient places complete faith and trust in a surgeon not only as a doctor but also as a good human being. Also involved is a matter of confidentiality. The surgeon becomes privy to privileged information, divulgence of which may not be in the best interest of the patient with regard to employment, finances and other personal matters.

What may be possible may not necessarily be ethical. The indications of surgery, therefore, have to be carefully weighed to provide what is best for the patient. Often surgical procedures are performed even though there is no definite indication for the same. Cholecystectomy is one such procedure which is performed even when not indicated. After the advent of the laparoscopic technique, the practice of removing normal or asymptomatic gall-bladders has become more prevalent, and is probably the commonest example of such unethical practice.

It is not uncommon to come across patients who have supposedly had a diseased organ removed (e.g. gallbladder or appendix) but have persistent symptoms: re-evaluation reveals the ‘diseased’ organ to be intact. Standard medical practice mandates histological examination of every tissue removed. However, this is often not the case and leads to wrongful and delayed treatment.

Informed consent is yet another important ethical consideration. The individual autonomy of a patient must be respected. The process of obtaining consent is required to improve the patient’s satisfaction and compliance level, and ultimately contribute to a healthy outcome. The patient has to be given the right to make a decision. In special circumstances, surrogate decision-making may be justifiable (in patients who are unable to think, understand and/or take a decision on their own).

Non-initiation or termination of medical care in hopeless clinical situations is also an important aspect of ethical surgical practice. Patients with advanced malignancies are often denied admission from the outpatient clinic itself, even though they are symptomatic, since control of the primary disease process or even worthwhile palliation is not possible, and the patient’s only requirement is terminal care. Many end-stage chronic progressive medical disorders also come under the same category. Not many institutions in the country can afford to have facilities for the terminal care of patients. I was party to a decision where a patient with end-stage chronic renal failure had to be denied further dialysis since he could not receive a second renal transplant, and the family could no longer afford the cost of repeated dialysis without jeopardizing the interest and future of the other family members. Similarly, an elderly patient with large bowel obstruction due to an advanced malignancy was allowed to pass away quietly in one of the hospitals abroad, despite the fact that the obstruction could have easily been relieved by a colostomy. The procedure was denied as the patient was not in a condition/state of mind to take care of the colostomy herself and there was no one to look after her.

In a wider perspective, therefore, ethical decision-making regarding non-institutionalization as well as discontinuation of resuscitative measures in certain critically ill patients is a part and
parcel of surgical practice. Euthanasia has in itself become a subject of larger debate. Clear instructions and guidelines must therefore be evolved regarding the quality of care to be provided in end-of-life situations. One is duty bound to provide appropriate palliative care but respecting reasoned decisions to forgo treatment after mututal discussion may not be unjustified in specific situations.

The care to relieve or control pain, uncomfortable symptoms and the institution of life-sustaining treatment or support goes a long way in providing relief to a suffering person, the family members and friends. However, most institutions in India have a large workload and not enough resources (including manpower) to care for such patients. Domiciliary or special centre-based care in these situations needs to be evolved and practised.

The ethical issues related to the development of complications during hospital stay following a surgical procedure or the occurrence of hospital-borne infection also need to be seriously considered. Not only do these situations drain personal finances but also place an additional burden on the already scarce health resources of the state.

A number of hospitals offer 'package' deals for some commonly performed operations such as coronary artery bypass grafting. If a patient develops an unforeseen complication, procedure-related or otherwise, the hospital stay gets extended. If this involves treatment in an intensive care unit, the charges go up steeply. Though a complication may be an accompaniment of an intervention in a proportion of patients, should the patient suffer the physical, mental and financial burden? One often comes across people who have lost all that they have in trying to save a close relative. This is also a strain for the institution treating such patients. The implications are thus multifaceted for the individual as well as for hospitals. Every effort should be made to minimize these situations by introducing routine surgical audit to critically analyse results.

Surgical audit should be an essential part of surgical practice in order to assess the quality of care being provided and to improve the outcome. The evidence collected would guide and influence surgical practices and possibly change them for the better. A particular method of treatment or an operative procedure can no longer be left to personal whims and fancies, since alternatives abound and the choice would depend upon the given set-up, infrastructure and the level of professional competence available. The best and safest surgical procedure in a given clinical situation is the one which provides the best clinical outcome. Such procedures have to be identified and only those which provide optimum benefit ought to be practised on a regular basis. The compulsions therefore have to be to choose a consumer-friendly option and these restrictions should not be taken to mean curtailment of one's professional freedom. An ethically justifiable action under the circumstances is, therefore, one where the surgical approach is critically analysed beforehand and practical skills applied to maximize patient comfort and benefit.

There are limitations of an individualistic approach vis-à-vis pooled wisdom. In a complex clinical situation, one ought to judge correctly when appropriate cross-consultations may become necessary and be more beneficial to achieve a suitable outcome. A fresh input, even from a less experienced team member, may be helpful. Cross-consultations from other colleagues should be accepted in the right spirit and should never be denied to a patient. A surgeon has to be open-minded, and must respect the differences of opinions expressed by other colleagues.

The health care facilities provided in a country have to be commensurate to the needs of its people. While primary or community health care is essential, secondary and tertiary health care centres and apex institutions with highly specialized medicare objectives are also required. At the same time, unequal distributive justice would not be ethically acceptable. Within the citadels of health education, the distribution of resources between various disciplines and departments should also be done as per the demands and requirements of society. There is, therefore, a need for transparent institutional and professional policies.

ETHICS IN SURGICAL TEACHING AND TRAINING

The teacher and the student are equally involved in the training of young surgeons. Most residency programmes are devoid of ethical instructions as these do not constitute any part of the existing structured teaching and training programmes. There is thus a need to include ethical instructions in all courses in order to make young residents recognize ethical issues in clinical practice, identify hidden values and acknowledge the existence of areas of conflicts. A detailed curriculum should be introduced at all levels and should include ethical guidelines for personal and professional conduct. A uniform curriculum could be defined by a national body such as the Medical Council of India under the supervision of the Ministry of Health, Government of India.

On the part of teachers, their personal conduct and commitment to the training of residents as well as their complete participation in teaching activities on a regular basis would go a long way in the cultivation of healthy ethical practices. The practice of teachers not participating in teaching sessions, coming late and making critical remarks or comments without scientific evidence do little to inculcate ethical practices among students. Feedback of a teacher's performance should also be introduced in all colleges and institutions, which should be considered while evaluating their yearly performance.

ETHICS IN SURGICAL RESEARCH

Surgical research involves multiple and complex issues concerning not only ethical, but also legal and social considerations. By and large, the guiding principles remain respect for the other person, due consideration of a risk–benefit ratio in favour of the patient and clear intention to do only what appears to be justifiable in a given situation. Fraud in surgical research is as unethical as in any other area. Modification of research proposals, toning them down for easy ethical committee clearance and the desire to better one's results by paying less attention to ethics are unacceptable.

Publication of fabricated data, plagiarism and 'gift' authorship are among the well-known unethical practices.

In conclusion, I would like to re-emphasize the need for the ethical aspects of surgery to be taken up seriously in the Indian context. All medical institutes, particularly those running post-graduate training programmes, should introduce strict controls and monitor ethical practices. Only then would it be possible for surgery to stand out as a better and more user-friendly scientific discipline in this country.

REFERENCES


SINGER PA, MACDONALD N. BIOETHICS FOR CLINICIANS: 15. QUALITY END-OF-LIFE CARE. CMAJ 1998; 159: 159-62.


REGIONAL TRAINING COURSE ON BIOINFORMATICS APPLIED TO TROPICAL DISEASES IN SOUTH-EAST ASIA: A WORKSHOP SPONSORED BY TDR AT THE FACULTY OF SCIENCE, MAHIDOL UNIVERSITY, BANGKOK, THAILAND, 9-23 JULY 2002

The Regional Training Course on Bioinformatics (Computational Biology) Applied to Tropical Diseases is an initiative designed as part of the activities of WHO/TDR in collaboration with Mahidol University, Thailand. The aim of this initiative is to promote the capability of endemic countries scientists to apply cutting edge DNA technology to tropical diseases research. The objective is to introduce participants to basic information on the application of genome information and the potential for development of tools that can be applied to tropical diseases research. The regional two-week training course will focus on bioinformatics (computational biology) concepts with specific emphasis on the tropical diseases in the TDR portfolio (malaria, tuberculosis, dengue, leishmaniasis, Chagas disease, African sleeping sickness, leprosy, filariasis, onchocerciasis, and schistosomiasis).

COURSE OBJECTIVES AND GOALS

The objective of the course is to train young investigators and encourage application of bioinformatics/computation biology to pathogen genome research and development of new products against tropical diseases. Effort on the course will also be devoted to promoting multidisciplinary and international networking in order to facilitate south-south and north-south collaborations in computational biology/bioinformatics and tropical diseases research.

The first course will run for 2 weeks (9-23 July 2002) at the Center for Bioinformatics and Applied Genomics (CBAG), Faculty of Science, Mahidol University, Bangkok, Thailand. Preference in allocating the limited number (20) of places on the course will be given to scientists with a strong background and the potential to apply the knowledge and expertise gained from the course to research, and to training others in an effort to increase capacity in bioinformatics at their home institution.

Criteria for selection: Twenty candidates will be selected from scientists and researchers from South-East Asian countries, based on the following selection criteria: Good biochemistry and molecular biology background; expertise in using the internet and computers; fluent in English; involvement in tropical diseases research projects; potential of using bioinformatics for research in home institution.

Application procedure: All applications must be submitted via web-based procedure. The application form is available to download at http://www.sc.mahidol.ac.th/scb/cbag/applic.htm. Those interested should complete the form, include two reference letters from supervisors and/or senior colleagues, and send all documents by email to scwsr@mahidol.ac.th.

Application deadline: 28 February 2002; Applications submitted after the deadline will not be considered.

Course website: http://www.sc.mahidol.ac.th/scb/cbag/index.htm

Venue: Faculty of Science, Mahidol University, Rama VI Rd, Bangkok 10400, Thailand

Fee: There is no registration fee for the course. Selected applicants will receive financial support for travel and participation.

Course language: English

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