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LECTURES ON

MEDICAL ETHICS

YAHYA KIYAK, M.D.

MARMARA ÜNİVERSİTESİ

Istanbul — 1987

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LECTURES ON

MEDICAL ETHICS

YAHYA KIYAK, M.D.

Lecturer of Medical Ethics at Marmara University Medical School, Formerly Docent of Pathology and Forensic Medicine at Ankara Medical School, A Practicing Psychiatrist in Michigan, U.S.A.

Marmara Üniversitesi Kütüphane ve Dokümantasyon Daire Başkanlığı
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İstanbul — 1987

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PREFACE

The lectures on Medical Ethics to first year students of Marmara Medical School are brought together in this book. Because of language difficulty of our students, a rather simle English is used in the book. Since 20% of the students are from other nationalities, international codes are given as well as Turkish codes of medical ethics, laws and regulations.

It was necessary to give a brief medical knowlege in every subject since our students just came from high school and did not know medicine more than a lay person.

Although I acknowlege that the best teaching is by giving examples and case histories, I could not give more space to them because of the economic reasons. Also for same reasons the quality of printing paper is so poor

More emphasis is given to Islamic and Turkish viewpoints since it is very difficult to find them in contemporary western books on medical ethics. To incorporate Islamic ethics to medicine was not easy because of the poor literature in this area. Moral principles, codes of ethics and ethical philosophies are mentioned as much as this small book can permit. The main reason to give priority to principles is to stimulate the student to think and decide by himself when he confronts with the problems in his practice of medicine.

I tried to include most of the subjects on current medical ethics. Many subjects are fairly new, such as organ and tissue transplantations, brain death, computers, behavior modification, artificial insemination, population control etc. These are the popular subjects for the last decade or so even in the daily newspapers and other media news. Human rights movement brought in new areas and changes in confidentiality, in truth telling, in abortion, in transplantations etc.

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Turkish Medical Ethics Regulation and Declarations of the World Medical association are included in appendices for an easy reference.

My special thanks go to Prof. Dr. Ali Erluğrul, the founder and first dean of Marmara Medical School, who encouraged me to publish my lectures. I am grateful to Berhan Tosuner, M.D. who allowed me to include his lectures on "Quackery", "Medical Malpratice" and "Consultations" in this book. Also special thanks go to my cousin Vural Kiper who provided me with the literature on Islamic ethics. I finally thank to my doughter Havva Asuman Kıyak, Ph. D., Profesor of Psychology at the University of Washington for her reviewing the text and supplying me with literature. I also thank to typesetter Ali Baykal and Fatih Yayınevi who showed all the efforts in printing. Because there are no proof reading practitioners in Turkey and typesetter does not know English, there are too many errors in spelling and syllables. Even thoug an error sheet is included, I am sure there are many other misspellings. I apologize for these errors.

I hope this little book will be helpful to medical students as well as the practicing physicians.

Suadiye, Istanbul - April 1987 Yahya KIYAK, M.D.

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INTORDUCTION

Welcome to the medical profession. It is a fascinating, exciting, challengging, noble, productive and gratifying profession. You will deal and interfere with the process of life and death. You will be frustrated by losing your patients, possibly due to your lack of knowledge and skills, due to a lack of tools and facilities, and more often than people think due to the fact that we still do not know all the facts of medicine. We have oversold ourselves to the public. No matter how much and how fast science has progressed in the last one hundred years, our medical knowledge is still limited. But in spite of your frustrations, you will be gratified with the fruits of science, the saving of a life, the ability to sooth physical and mental pains and agonies of a human being. You will have the respect of your community. People will see you as a knowledgeable tender, loving and caring father figure. They will see you as a wise man or woman. They will ask your advice even in non-medical areas, such as the marriage of their doughter. In almost every nation in the world, surveys have shown that physicians have the highest respect and honor among all professions. Early physicians were divine, almost half Gods. We see this idea in Mesopotamian and especially in Egyptian medicine. As in the earliest cultures, the Shaman is a physician who has a unique ability to communicate with God in healing.

You will belive in God more than ever, after you learn medicine, because you will see in basic sciences that no human being is able to create so sophisticated and perfect a machine as the human body. The Arab philosopher Cahiz in the eight century A.D. said: «I wonder if a physician does not believe in God after he studies anatomy.»

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TERMINOLOGY AND DEFINITIONS :

Ethic or **Ethical** comes from the Latin word **Ethicus** or the Greek **Ethicos. Ethos** means custom or habit; **Ethicus** or **Ethikos** means relating morals, the treating of morality, containing precepts of morality, shortly **moral.**

According to Webster[96] **ethics** is «The study of standars of conduct and moral judgement; moral philosophy»; **Ethical** is man's moral state, it is :

1) Having to do with ethics or morality; of or confirming to moral standards.

2) Confirming to the standards of conduct of a given profession; as it is not ethical for a judge to hear a case involving his own interests.

In Turkish medical schools the term of **Deontology** is used. It comes from two Greek words : **Deontos** and **Logos.** The first word means **Duty,** the second **Knowledge** or **Science.** So Deontology means «The theory of duty or moral obligation». The term Deontology as first used by Jeremy Bentham in his book «Deontology or the Science of Morality» in 1834( ). I prefer the term «Medical ethics» used in English speaking schools, instead of «Deontology». You can't find the word of «Deontology» in book lists or liberary cathologues in English speaking countries.

Here are some definitions of Ethics : «Ethics is the science of duty; it deals with moral qualities and teaches the necessary rules to be followed «Ferit Kam[51]. «Ethics is to know one's personal and social duties and obey to rules of religion «Hamdi Akseki[6] Akil Muhtar Özden[66] uses ethics and moral in same meaning and defines it as : «The rules of life which show how to live happily and in a beneficial way and help to gradual evolution of fhuman being». Osman Pazarlı[68] defines ethics as «The science of ideal regulations (laws) which controls men's behavior and art of best application of them in different situations». Our Profet Muhammed says «Tahâllaku biahlâkillahi = Make your conduct as Allah orde-

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red[68] «Hassinu ahlâküm biahlâkillahi = Make your virtue beatiful as Allah ordered»[68] Further definitions by other Moslem ethicists : «The science of ethics is concerned with goodness; it is the science of duty» İsmail Hakkı İzmirli[68]. «The science is a tree and ethics is its fruits» Gazali[68]. «The science of ethics is a part of practical wisdom. It teaches how to obtain virtues and how to avoid infamy. Its subject is the high moral character and gained virtues» Kâtip Çelebi[53]. Kınalızade Ali Efendi[56] rather studies the personal ethics and says «Personal ethics is the duties of man to himself and to God. The science of ethics is the spiritual medicine which treats bad morals (infamy) and maintains virtues; the bad moral and acts are the signs of illness of the mind». Ronald Munson's[64] definition seems rather comprehensive : «The branch of philosophy that is concerned with principles that allow us to make decisions about what is right and wrong is called ethics or moral philosophy. Medical ethics is specifically concerned with moral principles and decisions in the context of medical practice, policy and research».

Paul Ramsey[71] means by «ethics» «the science of right or wrong conduct, praise-or blameworthy behavior»

Trere are two parts of ethics :

1) **Practical Ethics** concerns with doing ethical duties. It teaches us our duties and obligations to ourselves, to our parents and to other people. It teaches us to confirm with value judgements. This can be said as «Treat others as you wish to be treated.

2 — **Theoretical Ethics** is also called as theories of ethics and **philosophical ethics.** It does not give ethical orders and does not deal with value judgements. It studies how the responsibility arises, how does responsibility develops from conscience and what is its goal. Theoretical ethics studies the meaning and goal of ethical issues. In our lectures, we will consider both practical and theoretical ethics.

WHY DO YOU HAVE TO LEARN MEDICAL ETHICS? Medical ethics teaches :

1 — What are our duties and responsibilities (to our patients, to our society and to humanity, to his colleagues, to his subordinates, to his family and to himself)?

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2 — What is right and wrong in our duties in medical practice, research and policy?

3 — What are the accepted standard rules, regulations and law?

4 — What are the philosophies behind a given principle and rule?

5 — How are these rules influenced by different cultures, societies and times?

WHAT ARE THE SOURCES OF MEDICAL ETHICS?

1 — Accumulated knowledge of virtues, values and accepted standards in us since we were born.

2 — Family, society we live in, lectures in grammer and high schools on ethics, psychology and other social sciences etc. Our consience has developed since we were a baby.

3 — Lectures on medical ethics in medical school.

4 — Every teacher of yours in medical school. Listen your teachers and observe their behavior; they accumulated a wast knowledge in their practice and experience. Most teachers will try to give you «a piece of advice» which is gained in his or her long practice and teaching. Some of them are good in medical arts, in their conduct to patients and others.

5 — **Oaths** such as Hippocrates, Maimonides, International, Istanbul, Ankara etc. Medical Schools' oaths.

6 — **Codes** : such as the codes of American Medical Association, British Medical assn., Tıbbi Deontoloji Tüzüğü of Türk Tabibler Birliği.

7 — **Laws** such as Tababet ve Şuabatı sanatlarının icrasına dair kanun and Türk Ceza Kanunu, Organ ve Doku Nakline Dair Kanun etc.

8 — Medical and Paramedical Jurnals such as Journal of American Medical Assn., Hasting Center Report, Bioethics Quarterly, Ethics in Science and medicine, Journal of Medical Ethics etc.

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9 — Declarations by World Medical Association such as Declaration of Geneva, Helsinki, Sydney, Oslo, Tokyo and Havaii, etc.

THE GOALS OF MEDICAL ETHICS ARE :

1) Doing right in your practice, research and conduct with others.
2) Knowing the right way before you make a serious mistake.
3) To avoid humiliation.
4) To avoid malpractice suits and punishments by your professional society.
5) To gain respect from patients, society and your collegues.
6) To be confortable with your own conscience.
7) To be respected, comfortable and happy physicians.

A SHORT HISTORY OF MEDICAL ETHICS :

The history of medical ethics must be as old as the history of medicine, but there is not enough evidence how much the physicians cared about the ethics. Holy books of Veda (15-20, Cent. B.C.) and Susruta - Samhita (Medical writings in 6. Cent. B. C.) in India contained some information on medical ethics such as medical practice, physician's duties and rights[5]. In old cultures (Mesopotamia, India, Egypt etc.) disease is believed a punishment by God and can be helped only by God with the mediation of priest-physician. In that case there is no responsibility or ethical obligation of the therapist. However, surgeons who were different than priest - physicians might be punished for their wrong doings. The Code of Laws of Hammurabi (1790 B.C.) regulated fees of surgeons who were rewarded in accordance with the patient's social and economic status, whose failures were punished with mutilation (Eye-for-an eye principle).

The Hippocratic Oath is the earliest guide to show the principals of medical profession which showed the standards of physicians' conduct with his patients, their relations with their students and teachers, confidentiality, abortions etc. Hippocratic tradition was amalgamated by Judaist, Christian and Moslem ethics. When

new technics developed and society's attitudes changed in the bebinning of 20. th century, modification of Hippocratic oath was necessary. During the last 20-30 years society's attitudes on abortion, quality of life, tortures, sterilization, birth control, human rights and new techincs as organ and tissue transplantation, artifical insemination, re-animation, brain death developed. Certainly these developments and attitudes brought new ethical dilemmas.

Islamic medicine followed classical Greek medicine; Moslem physicians integrated Hippocratic tradition with the ethics of Islam. Razi (854-932), Farabi (870-950), Biruni (973-1051), Ruhavi[74] and Ibn Sina (980-1037) contributed to medical ethics in their writings. According to Şehsuvaroğlu[81] 5 out of 50 medical books of Razi concerned with medical ethics. Yusuf Has Hacib, a Turkish statesman in Karahanlı Devleti, gave priority to medical ethics in his famous book Kutadgu Bilik (1070). Ottoman Turks regulated medicine with Kanunnames, the physician could be held responsible for his failure in treatment, especially for post-operative fatal results. Ottoman physicians put greate emphasis on tfe qualities of physician, their bedside manners and their relations with their patients. Ottoman physicians such as Hacı Paşa, Sabuncuoğlu, Eşref bin Muhammed, Ibn Şerif, Emir Çelebi, Abbas Vesim and Hayrullah efendi contributed to medical ethics[81]. «Şifa al-Eskam» by Hacı Paşa, «Enmuzec al-Tıp» by Emir Çelebi[27], «Düstur-ul Vesim» by Abbas Vesim[1], «Makalat-ı Tıbbiye» by Hayrullah Efendi[41] are good books in medical ethics. These writers put more emphasis on virtues of a physician and bedside manners.

A. Süheyl Ünver made great contributions to medical ethics in modern Turkey. In addition to his several conferances, he wrote books and articles on medical ethics. Translation of «Çehar Makale[88]. Tarihte Ameliyattan evvel Şifahi Senet Almağa Bir Örnek[89], Tıbbi Deontoloji»[87] Lokman Hekimin Sözleri ve Menkıbeleri are among them. Bedii Şehsuvaroğlu[81] published his book «Tıbbi Deontoloji» in 1975 which is the firs organized teJtbook in medical ethics in Turkey. Emine Atabek[9] also published a good book «Tıbbi Deontoloji Konuları» in 1981 in which there is a good integration of law into medicine. Nil Akdeniz[5] investigated almost 2.000 manuseripts (Ottoman) and published her book «Osmanlılarda Hekim ve Deontoloji» in 1977.

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TEACHINGS IN MEDICAL ETHICS :

In old times medicine was taught to one or few apprentices or students by experienced physicians; namely it was a Master - Apprentice (Usta - Çırak) type of teaching. Medicine was an art as well as a science, as it is now. The student learned medicine together with ethics from his master. We continue to do this in our times but in the organized schools.

Teaching medical ethics started in Viana, Paris and Berlin Medical Schools after the mid 19. th century. According to Arslan Terzioğlu[82] Nahabed Roussinian efendi gave lectures in medical ethics at Mekteb-i Tıbbiye-i Şahane (Istanbul Medical School) from 1874 to 1876. Then these lectures were given by Dr. Joseph Nouridjan till 1881. The name of the course was «Ilm-i Hüsn-ü Ahlak-ı Tıbbiye» («Güzel Tıp Ahlakı Bilimi» in modern Turkish and «Good Medical Morals» in English.) After 1881 these courses were given off and on by different teachers including Hüseyin Remzi Bey. After the second constitutional Reform (Ikinci Meşrutiyet) in 1908, when civilian and military medical schools were integrated at Haydarpaşa as «Tıp Fakültesi» in 1909, Muallim Dr. A. Zoeres Paşa gave lectures as «Tarih-i Tıp ve Vezaif-i Etibba». After some gap in time Muallim Dr. Galip Ata Ataç taughth medical ethics in 1925-1927. In 1932-1933 Müderris Dr. Akil Muhtar Özden gave some course in medical ethics. After the University Reform of 1933 Doç. Dr. A. Süheyl Ünver officially became the head of «Tıp Tarihi ve Deontoloji Kürsüsü» until his retirement in 1967. At that time this department was headed by Dr. Bedii Şehsuvaroğlu, then by Dr. Arslan Terzioğlu. Medical History and Ethics department at Ankara Medical School (Established in 1946) was headed by my late teacher Dr. Feridun Nafiz Uzluk.

A survey by Robert M. Veatch[91] in 1971 at 94 medical schools in USA showed : 15 have no teaching in the field of medical ethics. 56 of them claimed that issues of medical ethics arise in related courses and clinical experience. The courses were; community medicine, social medicine introduction-to-the patient type courses, legal medicine, psychiatry, public health. 84% of respondents accepted the need to initiate or furher development of medical ethics or related education in their schools. In some schools there are emerging interfaculty programs in medical ethics which have not only

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with the medical school, but with teological, law and public health schools and philosophy departments. In a later publication[91b], Veatch and Soilitto reported that in the USA the number of Schools with special programs tripled between 1972 and 1974.

There is not a general agreement on who sould teach medical ethics. A nationwide conference[91] on this topic was held in the USA in 1972 sponsored by «Institute of Society, ethics and the Life sciences and Columbia University College of Physicians and Surgeons. According to the proceedings of this conference, the teacher of medical ethics should have training in social and behavioral sciences, human biology, the basic medical sciences and psychiatry. The above mentioned study of Robert M. Veatch[91], showed that medical ethics was taught by mainly chaplains, ethisists and physicians. He says : «There may be as many as 30 more people in the USA outside of the medical schools who are also devoting at least half their time to the discipline of medical ethics. Altogether we may be dealing with a critical mass of some 40-50 professionals who consider medical ethics or a closely related discipline to be their primary area of specialization».

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THE ATTRIBUTES AND QUALITIES OF A PHYSICIAN

There are 24 aphorisms (adages, a brief statement of a truth) from Hippocrates. They were translated into Turkish and furher detailed by Hayrullah Efendi and Feridun Nafiz Uzluk[84]. These aphorisms were followed for 2400 years and they are still generally valid today.

1 — Medical study should be started at an early age.
2 — The physician should be medium in height and should be very careful in his body hygiene.
3 — The physician sholdd be in good moral character.
4 — The physician should be honest.
5 — His being honest is not enought, he should not have any relations with dishonest people.
6 — He should not be friendly with dishonest people, otherwise his patients will not trust him.
7 — The physician should stay with his patient just enough time, not too long. He should not express unnecessary pity, he should not neglect his necessary treatment because of bitterness of drugs and the fear of hurting the patient physically.
8 — The physician should be soft spoken.
9 — He should not be too ambitious for money.
10 — He should not do unpleasant acts contrary to the public's values such as drunkenness.
11 — He should go to his patient on time.
12 — He should be careful in his manners while with the patient.
13 — He should keep the confidentiality of his patients.
14 — He should not prepare medicine himself.
15 — He should not go to his patient a second time unless he is asked to do so.
16 — He should follow new publications and technics in medicine.

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17 — He should not give new medications before they are tested well.
18 — He should not need the support of others for the maintenance of his life.
19 — He should not perform abortions and should not give poison.
20 — He should not belittle anybody.
21 — He should be honest in consultations.
22 — He should not be friendly with people of bad reputation.
23 — He should not be egoistic.
24 — He should not reveal his decisions and plans unless he comes to a conclusion.

The physician's body built and attractiveness may impress the patients, but even crippled physicians can find a suitable position in the medical field to be successful and helpful.

It is a very difficult task to practice medicine; therefore he should be healthy himself. He should be ready any time he is called upon for help.

The physician's body hygiene and dress are very important. He should take baths frequently and shave everyday, should brush his teeth, even should use mouth sprays and deodorants often because he is physically close to his patients during examinations. Physicians should follow the popular fashions a little later than the general public.

The physician should be sympathetic, polite, graceful, confident in himself.

A physician should not smoke. Smoking is a bad acquired habit, never start it. If you already started smoking, quit it soon while your neural transmissions are not dependent on it. There is no question at this time that smoking definitely causes cancer and cardiovascular diseases.

The physician should be honest and should never lie. He should be kind, compassionate, caring and most important of all, loving. Loving the people is not easy but extremely desirable. All the profets and most of the philosophers impressed the importance of love but we could not understand it well. Don't forget, all men are crea-

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ted in God's image. Loving the human being is loving God. All our mystic beliefs circled around this fact. Mevlana, Hacı Bektaşı Veli, Yunus Emre and others are trying to teach us to love others and God. Love is more important for the physician than any other profession. Otherwise you could not help people. The physician should have the humane warmth; he should be a humanist.

The physician should be polite and soft spoken. He should respect the customs and habits of his patients.

To keep appointments with patients is crucial in medical practice. The patient is suffering, he is fearful and full of anxiety. Your being late makes him feel that you don't respect him; you don't care about him as a person. Call your patient if you promised do so. Be on time to see the patient as you promised.

The physician should be tolerant and should have a great patience. We are human beings; we can't avoid anger. But the patient is a suffering person, dependent, unreasonable and like a child. Most of his enxiety comes from not knowing the nature of his illness. As a general rule we should **accept the others as they are.** This is more so in medicine. Don't get angry at your patients. If you can not control your anger. immediately apologize to him. An apology does not degrade you; in fact you are a mature and ideal person when you are able to accept your faults and ask the patient's forgiveness. Say : «I am sorry, I lost my temper». The other rule of thumb in this respect is : **«Treat others as you wish to be treated».**

The physician should be brave. We are like fire fighters, as the fire fighter enters into a fire, so we enter into an infectious environment and into the fire line.

Do not examine an opposite sex without the presence of someone from that same sex if possible. This could bring law suits and blames; you could lose the respect of people. Never forget the fact that we all have evils in ourselves. This is called «id drives» in psyhoanalysis. Being alone with the opposite sex could encourage your and your patient's id drives. This impulse could be restrained more easily when somebody is present

I hope you did not come to medical school because of a great desire to be a wealthy person. It is a fact that no physician becomes a billionaire by patient fees. While I was a student almost 40

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years ago, I was told that there had been only one millionaire physician in Turkish medical history; he had made his fortune by wise investments, not by patients' fees. I have seen millionaire physicians in the USA, but they had built their fortune by wise investments. If you try to make a fortune by patient fees, you will be a robber; if you want to be a robber, you had better look into other areas. Because you have higher intelligence, you coud do better and wise investments. There was a radiologist in the past who invested his money to buy property in Egean shores in 1940 s when nobody was interested in sea shores. 15 years later he was a millionaire. Although in the early years of your residency and practice, you will have some financial troubles, sooner or later you will have financial security and a generally comfortable life. The most important thing for human beings is to be happy in their lives. As Plato said **«Happiness is to know how to restrain your ambitions».** If you are modest enough and able to restrain your ambitions, you could be happy with your modest earnings. In this respect your wife's or husband's attitude is very important. If she or he married you because he or she thought you will be a wealthy person, you have troubles.

Be modest in your behavior. You can not know the whole medicine. After all medical science and technics are changing more rapidly today than ever before. Do not insist you are absolutely right. Do not use the words **«never», «absolutely»,** «in medicine. Do not say you will cut your hands or distroy your diploma if you are wrong. When you fail, others could embarrass you by saying «So, now you go ahead and cut your hands.»

Do not critisize a colleague in front of the patient especially when he is not there. Don't say you do a better job than he does. Don't belittle other specialties. Try to handle discrepancies tactfully. A peptic ulcer could be treated by an internist, surgeon and psychiatrist. Each of them are right. Do not insist the only way to treat an illness is surgical or vice versa. Another coleague's statement could be misunderstood or he told it in different conditions. Maybe he has seen the illness in a different stage. But do not defend your dishonest, unethical and harmful colleague

Medical practice is very difficult; it needs sacrifice from your own pleasure, rest and even your healt to help your patients. You could be awakened in the middle of the night and may have to make

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a hard trip in the winter to help your patient. You cannot say your child or wife is sick etc.

A physician should not be prejudiced. He should give the same quality of services to every person, no matter what the patient's race, creed, religion, political beliefs, social status etc. We will discuss this topic later more. Don't belittle your patients and don't make them ashamed because of their poverty, beliefs, dress, appearance etc. You could make jokes with patients but they should never hurt them. Be very careful in this respect. To be too serious is not recommended either.

Listen your patients carefully and take time in examining them. Learn how to avoid and handle the patient's irrelevant statements tactfully. Be very clear in your recommendations and statements; don't allow that your statement could be misunderstood. Use your nurse and written directions in your advice. Ask them if they have further questions. Do not hide the side effects and possible dangers; give them alternatives. If you think some other colleague could help better, don't hesitate to ask for consultations.

Honesty and telling the truth are essential, but again be tactful. Don't tell an already hopeless patient the gravest possible outcome. Never tell a patient how soon he will die, because only God knows it. If a patient asks insistently about it for arranging his last will and making legal, social and religious arrangements, tell him : «Only God knows when we will die; I have already made my last will because I may be killed in the next hour in a traffic accident.» This topic will be discuessed in more detail in the future es «Truth Telling» Even through you believe that patient has a very short time to live, give him hope and advice because even a short life can have meaning and mpments of pleasure. Total dispair is harmful to patient. In fact there are numerous case studies in the medical literature of patients who lived unexpectedly long because of optimism and because they looked forward to o major happy event, such as the birth of a grandchild or the granduation of a son or doughter. Never be hopeless. But don't be falsely over-optimistic either.

Respect each other, your teachers, coleagues, patients and even cadavers. The later is very crucial but unfortunatly we do not pay more attention to it. Be respectful to cadavers and autopsies.

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Never drink alcohol to the degree of being drunk. Social drinking may be acceptable but stress and possible frustrations in profession and family may easily cause alcohol dependence among physicians. Also habit forming drugs are avaliable to physicians, so it becoms doubly important to avoid these. Unfortunately alcoholism and drug addiction among physicians are higher than in the general population.

Physician should learn untill the end of his life. There is no end to medical knowledge. It is rather difficult to follow the medical literature which is growing more and more everyday. You are lucky to get training in English because you could find most of the medical literature in this language. I hope we will have a general medical journal like. The Journal of the American Medical Association in order to follow general medicine, as well as many specialty journals by the time you graduate.

The physician should be a very good observer. The following anectode is arttribute to Rudolph Virchow, a famous 19.th century German Pathologist and the father of Modern Pathology. During an interview to select candidates of Medical School, Virchow asked to o candidate : «Son, a doctor should be brave. Let us see how brave you are. When I was young, we tested sugar in the urine by tasting it.» Virchow put his finger into the urine and licked it, then asked the student candidate either he could do the same. In order to show his bravery, the young candidate put his finger into the urine and licked it. Dr. Virchow said to the candidate : «Yes son, you are a brave young man but you are not a good observer. I put my index finger into the urine but licked my middle finger, not the same finger I immersed into the urine.»

The medical student should ask everytime whenever he sees and reads something unusual **«Why?» , «What?» , «How?».** Never forget this. «Why» is the cause, «What» is the pathology and «How» is the physiology. Be a research mined. Ask questions to yourselves, **know what you don't know, don't be satisfied with what you know.** Take notes for new things you observe or you write down an idea just when it comes into your mind, then try to look for answers to it. Do not be hesitant to ask questions. Perhaps due to hiding our ignorance and bashfulness, Turkish students hesitate to ask questions. Don't hesitate. Your teachers are here to teach you and to satisfy you. Don't forget your knowledge

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in basic sciences such as anatomy, physiology, chemistry by the time you get into your clinical years. Each step of knowledge is closely related to each other. You cannot understand coronary disease if you do not know anatomy, physiology, pathology, pharmacology etc. This complete knowledge is bases to understanding the health of human beings. In elementary and high school you studied for grades and to pass the class. But in medicine you have to learn for yourself; you will be alone with your knowledge and your patient. Hiding your ignorance has no place in medicine. We ought to seek out knowledge and expose our ignorance first to ourselves, then to those who can hepl us. Solomon Papper([67]) says: «Not to recognize one's limitations is a serious matter, but to recognize them and not to act accordingly is an unforgivable testimony to personal vanity. Vanity has no place in medicine.»

Conscience has a great place in ethics. Conscience is knowledge or feeling of right or wrong; it is a moral judgerment that prohibits the violation of a previously recognized ethical principle. If we do a good act we feel at ease, comfortable and praud of ourselves. But if we do wrong, knowingly or unknowingly, we feel ashamed, deeply regretful and remorsful. Extreme remorsfulness may lead to self mutilation and suicide. Patient trusts to physician and leaves his life to his hands. There are many things physician do to his patient that only God and doctor himself know. If a physician does not feel remorse, it is too bad, it costs to patient's life. Physician who has a poor consicience is the most dangerous creature, like a winged tiger. (or like Frankenstein)

Physician shoul have a humiliation too. If physician does not feel ashamed of his conduct he is dangerous to his patient and to society. In our every decision and act, we have to consider what the others will think about us.

Be evnvious, not jelous of the people whom you think are better than you, try to reach that envious level by trying hard instead of putting obstacles in front of that person. Finally, do not forget the fact that medicine is a most noble calling.

The 9.th century A.D. Moslem physician Ruhavi([74]) glorifies qualities of a physician in his Risale so perfectly that they are still worth recalling today; he says : «Medicine is a profession giren by God to those whose hearts are pure, with a sharp intellect, and

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who love goodness, have a mercy, sympathy and chastidy.» Nobility is originated from its commitement to human health. In the Glorious Koran, Allah says : «Verily we have honored the ihildreen of Adam.... and we have preferred them above many of those whom We created with a marked preferment. (Isra or The children of Israel 17/70). «And when I have fashioned him and breathed into him My spirit, then fall down before him prostrated. The angels fell down prostrate, every one.» (Şad surah 38/72-74). So, the human body and its life are holy and a part of God. Our profet Muhammed Said many times in his hadiths that the science of medicine is higher than teology because an unhealthy man cannot pray (Nil Akdeniz) (5).

I would like to finish this subject with the words of Hippocrates to describe a mature man : «To be modest when he is in a high position, to be able to forgive while he is strong, to be able to give to others even when he himself is in need, not to remind one reproachfully of a kindness done to him.» (45)

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RESPONSIBILITIES OF THE PHYSICIAN

As a physician you will have responsibilities to your patients, to your society, to your colleagues, to the people who work with you, to your family and finally to yourself.

PHYSICIAN'S RESPONSIBILITIES TO HIS PATIENTS

The physician's responsibility to his patients has the highest priority. When we assume responsibility for the health of our patients, all other responsibilities should be placed in the baskground.

First of all we should see the patient as a person. We should take into consideration his fears, anxieties, goals, responsibilities and his socio - economic position. Especially patients coming from lower socio - economic areas and remote Anatolian villages are shy but praud. You should respect them and show that you accept them as they are. Talk them first about their district, whatever you know around their environment, at the very least about the weather (Selâm - kelâm in Turkish) to decrease their anxiety and to make the patient more at ease. Teenagers and menopausal women may be very touchy. We must be very careful in our attitudes and in our conversations with them Don't get angry at a senile older person who cannot tell his age or talks irrelevantly. Recognizing that this behavior is in fact a symptom of the disease. On the other hand do not treat your uremic or delirious patient as a mentally ill.

In modern medicine, unfortunately, we assume that the patient is a machine to be repaired, almost like an auto mechanic. With the help of laboratory we are able to diagnose correctly. The modern physician spends very little time with his patient. Most physi-

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cians in the USA have several examining rooms; the nurse takes the patient's history, sometimes the patient writes his own history, then waits half or completely undressed, finally the doctor comes, examines him in 5 minutes, writes a prescription, gives a short intruction and says : «Come back in one week.» Often such physicians would be unhappy if the patient asked questions; because he is so tightly scheduled he fears that he will be late for the next patient waiting in the next room. Mostly the patient is disappointed, dissatisfied with the treatment rendered and the physician. Such situations often form the basis for medical malpractice. This is not good medicine.

Often patients complain that the physician does not spend enough time with them. There could be several reasons for this : 1 — Physician does not realize some patients need a little more time, 2 — They do not pay attention to a particular patient's needs even though they know, 3 — They are too busy. On the other hand the physician may give enough time but some patients want more and more. Very possibly these are neurotic patients. At this point, you may consider fererring the patient to a psychiatrist after explaining the necessity of psychoterapy. Your time with the patient should not be interferred by telephone calis or other means.

Some patients deliberately and knowingly take your time. It was in early months of my practice in psychiatry, a patient's mother used to call me long distance from NYC. First I tried to satisfy her, even though I thought she was spending so much money for phone calls. Then I realized that it was cheaper to have therapy for her by phone than going to a therapist. I told her this fact, we both agreed she should call me in certain hours and be charged. This is also a good example of good physician - patient communication, otherwise I would be angry with her

As Conficius said «No man is good doctor who has never been sick himself». Also a Turkish proverb says : «You don't understand the patient's feelings if you have never been sick yourself.» I experienced this myself a few times in my life. When I was taken into the intensive care unite, I felt anxious, fearful, helpless and dependent. The medical staff's attitude, mood, sympathy and warmth had a great influence in my recovery. When I felt they saw me as «another case» I felt demeaned, I was angry, (Further examples of Göğüs Hast. Hast. Dr. and pediatrician).

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Try to make treatment cost as low as possible. Write cheaper but equally effective drugs to your poor patients. Do not prescribe them expensive and fancy rehabilitation places and spas. Do not ask for unnecessary laboratory tests. Tell patient about alternative treatment methods. Consider who will take care of their children or a sick mother when she is hospitalized. Think how much economic burden and worry rests with the patient. One big mistake I see in our physicians is that they rite several drugs in the same cathegory or one or more drugs for each symptom. This often leads to serious drug interactions and overmedication problems, especially in older patients whose kidneys and livers cannot metabolize drugs as efficiently. The cause of symptomatic treatment may be : 1 —Ignorance of a physician who cannot diagnose the disease, but instead treats each symptom seperately; 2 — has no time; instead of diagnosing thorouhly and accurately he gives medication for each symptom. 3 — The physician does not do sensitivity tests, but instead gives several antibiotics for an infection. I remember one of my neighbours while I was in high school said his doctor diagnosed heart disease, edema, enlarged liver and a weakness. Actually patient was suffering from a single illness, heart failure.

Do not critisize your colleague who has seen the patient earlier; instead praise the referring doctor. Some patients try to belittle the previous doctor in order to win your approwal.

Talk to the patient in a simple, clear and concise language. Do not go into details unnecessarily and irrelevantly. Tell him that whatever was discussed and whatever you know about him will be kept confidential unless you both agree to reveal all or part of information to certain people or organization.

Do not write a prescription without examining the patient. Do not be so overconfident in yourself that you believe you can diagnose correctly by just looking, even by smelling. You could miss a very important diagnosis in your patient. Ask lots of questions, check for family and personal history of many suspected conditions. Above all do a thorough physical examination.

Do not be unnecessarily shy. Right after my graduation from medical shool, a close friend of my father came to me with the complaint of bloody stools. I suspected cancer but I could not dare to ask him for a rectal examination. I recommended that he go to my

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teacher in Ankara. But he postponed his trip for several months. Finally he went; My teacher wrote back to me that my patient had rectal cancer and it was too late for surgery. I felt like a failure; because of my unnecessary shyness, a patient's life was at stake. Also I felt bashful to do vaginal and breast examinations. There is no need to be bashful because the patient has come to you for an examination.

Do not overcharge your patients. To have an X-ray facility and laboratory in your office brings you good fortune but this is a very touchy subject. If you are working alone in a remote district in Anatolia, it is good to have a small laboratory. Otherwise leave it to other specialists. Physician's distributing and selling drugs to patients was a big hassle in the past when there were no pharmacies in Kazas. Try not to give injections in the office. It could bring you a bad reputation and malpractice suits. If the patient passed out after injection in your office, do not charge him for your treatment of extra services.

Do not hesitate to look at a textbook in front of the patient to be sure about diagnosis and treatment.

Treat each patient respectfully and equally, no matter what their social status, wealth, age, sex, religion, political beliefs etc. Avoid unnecessary apple polishing.

We already discussed briefly earlier what to tell patients regarding a fatal diagnosis. Be respectful to a dying patient. You may break some of the little rules for the patient's last wish.

You must make a recording system. Unifortunately this is neglected in Turkey. I did not see a physician yet in Turkey who takes notes and records in each patient's folder. They ask the patient what they had found last time and what medication they had beem prescribed. This is a shame. We have to teach the public about follow up. They should know you cannot treat him by writing a prescription, you could change your prescription next week depending on the patient's reaction and possible complications.

Some patients do not know how to pay; they may even feel bashful about asking. In the past patients put the money into an envelope and slipped it into the physician's pocket after a house call or at the office. Respect the partient's pride, even though he

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may be poor. Send bills to patients who are able to pay but who try to take advantage of you. Try to give money matters to your secretary; this leaves you free to focus on going for your patients without being concerned about whether and when the patient will pay.

As we will discuss in more detail later, you can refuse to take care of some patients in certain circumstances. For example you have to notify your patients at least one month prior to your relocation. This is very important in psychoteharpy.

How friendly and how close we should be with our patients is a big question. In the United States, people call each other with their names if they are really close This creates a problem when you call your elderly patient with his or her first name. Especially in Turkey this is more important. Most of the time try to call with their titles such as «hocam, doctor, prof. etc» or call them» bey, hanım, beyefendi, hanımefendi, küçük hanım, küçük bey». For children, it is better to call them by their first names after you get acquinted. Calling old people with their first names may be viewed by patients as demeaning or infantisizing; they do not like to be treated as children. Ask your patient how he wants to be called if you are doubtful : «Can I call you with your first name?» Certainly you do not like to be called by your first name by your patient. Usually they call you «Doctor or Doktor bey». The patient may tell you to call her or him with his or her first name if they want.

Do not talk about your patients or their diagnosis in public, even if their disease is a rare case. Do not make jokes about them in public places, such as public transports, elevators, cafés etc. A teacher of mine used to say : «One does not have to go to medical school to learn medicine. Just take Bayazıt-Topkapı tramway and listen to medical students. «Prof. Emine Atabek(*) tells a good story about this subject. People were talking about a movie actress in a party. A young physician, certainly under the influence of alcohol said : «Yes I examined her; what a beatiful breasts, what a beatiful legs etc. she has. A lady sitting next to Atabek said «What a beatiful deontology.»

You should be careful to discuss persoonal and serious matters to patients in the right time and the right place. You and your patient could feel more comfortable to talk to them in a one-by-one

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basis. For instance we cannot ask personal and serious questions to the patient in front of the class. Sometimes this may create problems. You could tell them «Don't answer now if you don't want.»

In the past, physicians used French or Latin words in front of the patient to hide from him or from family members. This could create doubts and suspicions in the patient. Some of them did it purposefully to show of their language skills. Try not to mix original language with foreign words. If you cannot find a proper word in that language, it is acceptable to use foreign words.

If the patient needs continued help and you give an appointment but he does not show up, call him or write a letter to the patient about it. This is our moral obligation, also it saves you from a possible malpractice suit. The patient should be given an explantation as to why he needs continued treatment.

In particular, our peasant patients (Çarıklı erkânıharp) do not tell us their complaints. Instead they say: «If you are a doctor you should know.» Tell them you are not a magician (do not tell you are not a veterinarian).

Patients do not like to wait in waiting rooms. Try to see your patients by appointments. If they walk in, as usually happens in Turkey, give priority to elderly patients and the ones in pain and agony. Your secretary should be a bright and cheerful person, preferably a woman, «Excess waiting gives the patients the feeling of being demeaned and frustrated if not hostile.» [67]

THE PHYSICIAN'S RESPONSIBILITIES TO HIS SOCIETY

Because you are a respected and educated person, you have responsibilities to your society. Physicians should participate in the social, cultural, educational and recreational life of their community.

We should lead the public and influence authorities to improve public health, pollution, sanitary needs, community mental healt, parks and recreational facilities, cultural developments, education and research in community. We should help the poor and disabled, either directly or by encouraging the able citizens of our community.

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THE PHYSICIAN'S RESPONSIBILITIES TO HIS COLLEAGUES

It is a good tradition that physicians are like a fraternity. Brotherhood should be established and maintained among physicians. We used to call «Ağabey-Big brother» even to those students and colleagues who were one year ahead of us in medical school. I am happy this tradition is still present. Also the senior physician treats his junior as younger brother. This is much less prevalent in the west.

Mutual respect and love among physicians makes them happy, this portrays to the public an image of respect toward the medical profession. Physicians should maintain good relationships with each other. We should be fair, honest and openminded in professional disagreements. We should not protect, however, the dishonesty and incompetence of any of our colleagues. This kind of physician should be punished by medical societies.

When the supply of physicians increased, the jealousies and talking against each other started. This should be avoided. When we work harmoniously we can all make enough money to live confortably.

Do not talk against medicine in public, talk it with your colleague. A new physician should be welcomed by old ones.

Being formal or informal with your colleagues depends on your personality. To leave some distance between you and your friends maybe recommended. Do not be vulgar with your friends.

A physician should give priority to his colleagues and their families when they become ill. Traditionally the physician should not charge to his colleagues.

Medical Ethies Regulation says: «It is recommended that physician should not charge his colleagues and their dependents; however necessary expenses shoud be asked.» Charging your colleagues is a very touchy problem. When you do not charge, your friend feels as though he is imposing upon you, does not feel comfortable in the patient-physician relationship and tries to find some gifts as a «fair exchange.» In USA hospitals make full charges to physicians, doctors generally do not charge each other, but they are also unhappy. I feel they should charge each other but this should

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not be more than their necessary expenses such as laboratory costs, X-ray films and assistant's expenses, rent, supply etc. It is good to give samples to them.

The patient has the freedom to choose his physician except in certain situations. Especially in Turkey patients go from doctor to doctor, sometimes to check their correctness and to be sure. This comes mostly from distrust of the physician. We create this situation ourselves by being immodest. At times the diagnosis and treatment could be different because the patient was seen in different phases and situations of the disease process. It is important to tell the patient about this fact, namely the different phases of illness.

You have to send a patien's charts and information if he goes to another physician. If we are asked to make a house call for another doctor's patient, we should obtain his permission.

THE PHYSICIAN'S RESPONSIBILITIES TO HIS SUBORDINATES

Some people will work for you or under you. They should know that you are sincere, loving, honest and just; they should be given praise easily when they deserve it. They should also be kindly and tactfully criticized for their mistakes. Superior should take a kind and firm attitude like we do to our children. The best advice «treat others as you like to be treated.» You should be a model to your subordinates.

If you are a surgeon, do not think you are a God; do not kick your assistants in the operating room to relieve your insecurity. Unfortunately I observed this in my last year of medical school and I felt so angry and ashamed to be a doctor.

THE PHYSICIAN'S RESPONSIBILITIES TO HIMSELF

We have already covered part of this subject earlier in «Qualities.» We are human beings as well as physicians. We have needs, wishes, desires, anxieties and fears.

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We should ask our colleagues' help without any hesitation or humility for our own health. It is a common saying that «physicians are the worst patients», they neglect themselves.

The physician must look toward other sources of pleasure in addition to medicine. We have to have some hobbies such as reading in other areas : history, archaeology, literature, poetry etc. Some manual hobbies such as painting, music, carpentering, gardening, photography, watch repairing etc. are valuable for relaxation. Sports as hiking, jogging, golfing, table tennis, hunting etc. are recommended too. The physician should take time off for vacations with the family, planning well in advance so as to fit in with the family's, patients' and his or her own schedule.

The physician should have a few very close friends who accept him as he is, who listen and help him when he is in need, people who can be trusted, who can share joy and sadness with him.

THE PHYSICIAN'S RESPONSIBILITIES TO HIS FAMILY

As I have discussed the diverse responsibilities of physicians so far, you should by now have realized how much responsibility we have to society, too our patients, to our community and to our colleagues. We are exposed frustrations in our dealing with life and death. We spend a tremendous amount of time learning and reading. One wonders how in the world a physician finds time to raise a family and how he or she could be a good husband, wife or parent. It is difficult. First of all your spause should be understanding; he or she should assume some of your responsibilities.

Spare a reasonable time from your heavy schedule for your family. Make arrangements before hand. Give praise to your spouse easily for her or his help and understanding. Keep your spouse intellectually alive. Due to the above mentioned reasons the divorce rate among physicians is high. A female physician's husband should not intimidated or feel emasculated by the higher social position and earnings of his wife. Our families also deserve honorable and humane treatment.

A physician should try not to treat his family and himself because he cannot be impartial to his family and to himself. It is better to ask for a colleague's help.

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OATHS AND CODES

Oath means «A solemn affirmation or declaration, made with an appeal to God or some revered person or object for the truth of what is affirmend», **Code** means «Any accepted system of rules and regulations pertaining to a given subject; as the Medical Code, which governs the professional ethics of physicians.(96)

Hippocratic oath bound the physicians with moral and spiritual pledge to medical ethics and principles. The oath is attributed to Hippocrates (460-377 B.C.) and was followed by most of the physicians in different countries since then.

The Hippocratic Oath

«I swear by Apollo the physician, by Aesculapius, Hygeia and Panacea, and I take to witness all the Gods, all the Goddesses, to keep according to my ability and my judgement the following oath:

«To consider dear to me as my parents him tho taught me this art; to live in common with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the masters who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to produce abortion. But I wiill preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art.) In every

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house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commers with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep oath faithfull, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.»

Medical science has shown great progress since the time of Hippocrates, but main principles and moral values have shown not too much difference. Different societies in different times adopted Hippocratic oath with some changes in accordance to their beliefs.

Monotheist religions pledged to God instead of Gods and Goddeses, In the International Oath physician «solemnly pledge» himself and promises solemnly and freely upon his honor. During Ottoman times physician pledged while putting his hand on holly book. Ottoman physicians, as in many other countries, pledged the obedience to state and country and in the early period of Turkish Republic, to the principles of republic. Soviet physicians pledge to the principles of communist morality (Sidel).

International Medical Oath

(or the Declaration of Geneva) (1)

At the time of being admitted as a amember of the Medical profession :

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity;

(1) Adopted by the World Medical Association in 1947 in Geneva and amended in Sydney in 1968 and in Venice in 1983.

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The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;

My colleagues wil be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patients;

I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity;

I make these promises solemnly, freely and upon my honor.

The differences between Hippocratic and International Oaths :

1 — Instead of pledging to Gods and Goddeses, the modern physician solemnly pledges upon his honor.

2 — Hippocrates teaches medicine to a limited group (to his son, to his teacher's sons and to disciples who bound by an oath), in our times any able person can be a physician.

3 — International Oat emphasizes indiscrimination by saying «I will not permit considerations of religion, nationalty, race, party politics or social standing to intervene between my duty and my patients.»

4 — According to Hippocratic Oath the physician will give no deadly medicine to anyone if asked or do any abortion. In modern society abortion and euthanasia are acceptable in certain conditions. The International Oath says : «I will maintain the utmost respect for human life from its beginning.»

5 — Medicine and surgery were different professions during the times of Hippocrates and in the Oath a physician shoult not perform surgery. Now the modern physician

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pratices both surgey and medicine, namly he is both physician and surgeon; there is no provision in this respect in International Oath.

6 — International Oath continues the sentence (from item 4) as «even under threat and I will not use my medical knowledge contrary the laws of humanity.» This is not clear in Hippocratic Oath. During the war and terrorism physicians are forced to give the names of patients whom they treated. Nazi physicians used human beings as Ginea pigs in unimaginably terrible experiments. The International Oath clarifies this issue and physician will not use his medical knowledge contrary to the laws of humanity.

Before finishing this subject, it will be good to mention about Maimonides' prayer. Maimonides (1135-1204) is an Endülüs physician and scholar; he was converted to Islam by the name Ebi Ümran Ibn Meymun. He is a good interpreter of Judaism and Islam; he gave his services to Eyyubi dynasty. This prayer emphasizes the importance of the fact that physician should use all his kowledge and conscience in patient care.

Maimonides' Prayer (*)

I begin once more my daily work. Be Thou with me. Almighty father of mercy, in all my efforts to heal the sick. For without Thee, man is but helpless creature. Grant that I may be filled with love for my art and for my fellowmen. May the thirst for gain and the desire for fame be far from my heart. For these are the ehemies of pity and the ministers of hate. Grant that I may be able to devote myself, body and soul, to Thy children who suffer from pain.

Preserve my strength, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the man alone. When wiser men teach me, let me be humbl to learn : for the mind of man is so puny and the art of healding is so vast. But when fools are ready to advice me or to find fault with me, let me not listen to their

(*) Taken from Papper's : Doing Right. Boston. Little, Brown and Co. 1983

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folly. Let me be intent upon one thing. O Father of Mercy, to be always merciful to Thy suffering children.

May there never rise in me the notion that I know enough, but give me strength an leisure and zeal to enlarge my knowledge. Our work is greate and the mind of man presses forward forever. Thou hast chosen me in Thy grace to watch over the life and death of Thy creatures. I am about to fulfill my duties. Guide me in this immense work so that it may be of avail.

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ETHICAL THEORIES

Ethical theories are action guides which try to justify either our acts are right or wrong. Particular judgements and actions lead the development or rules, then principles and finally theories develop from rules. When we make a particular judgement and action in our practice, we measure the rightness or wrongness of our action considering the rules and principles in different theories. When we justify that our action is right we feel comfortable with our concience.

We have to consider that ethical values change from culture to culture and from time to time. For example, Eskimos leave their old sick people to die in the wilderness; this is ethical for Eskimos but unethical for us. Mentally ill persons were killed by stonning in medieval Europe; this act is unthical for a modern man but it was ethical in western culture because they believed that the mentally ill was possessed by demon. However, when we look carefully the differences are smaller now than we think. A good moral theory brings these differences as little as possible.

As a summary ethical theories help us in two ways : 1) They are action guides; before we do an action or judgement we consider the principles and theories and do the right action. 2) We do an act compulsively, then think retrospectively either it were right or wrong. With the help of principles and theories we could defend our position better and justify our act.

Ethical issues occupied human mind several thousand years. It is impossible to discuss all the ethical theories in detail here; they are very intricate. We will mention them here briefly. Later when we discuss some medical ethical problems we will try to show how we can justify our action with different theories.

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UTILITARIAN THEORY

Utilitarianism was originated from the writings of David Hume (1710-1776), Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873). Utility means usefulnes. Utilitarians say that what is right is what is most useful. This theory is also called teleological (telos = end) when we consider the consequences of actions. According to utilitarianism actions are right in proporrtion as they tend to promote happiness, wrong as they tend to promote reverse of happiness. It considers a sort of cost-benefit analysis. The right action is the one that produces the most benefit at the least cost. Mill and Bentham call this principle as «The greates happiness principle.» It may be formulated as : **the actions are right when they produce the greatest happines for the greatest number of people**- In this theory happiness is identical with the pleasure. According to utilitarian theory we can sacrifice a few people on research for the benefit of society; it is not unethical to lie for a physician for the benefit of the patient.

DEONTOLOGICAL THEORIES

Deontos means duty. An act is not necessarily right or wrong according to its consequences, its results for deontologists. According to deontologists the duty is very important; as long as we do our duty, our act is morally right. Deontological theories of Kant, Ross and Rawls are rather complicated; they emphasize rationalism. The intension, the intuition of person and performing the duty are important elemants.

ETHICS OF KANT

Immanuel Kant (1724-1804) believed consequences of an act are morally irrelevant. An action is right if it is done wit a «good will» to perform a duty in accordance with a rule. But this rule must satisfy the principle, Kant calls it, «Categorical Imperative» which means one's behavior should be governed by principles which one whould have govern the behavior of all people. Kant is a rationalist. Here the principle is an imperative because it is a command. Kant calls these principles as «Maxims». Maxim means a

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concisely expressed principle or rule of conduct; or a statement of a general truth; a percept. According to Kant all reasoned and considered actions are regarded as involving maxims. Examples to maxims are «Never lie», «Never kill» etc.

For Kant our action is right when it is done for the sake of «Duty». There are difficulties in Kantian theory in application because there could be conflicts of duties. Sometimes we cannot decide which duty has precedence to another duty. Kant did not formulate precedence of maxims. Other difficulties are that how everyone can agree about a maxim? Are we all rational beings?

ETHICS OF ROSS

W.D. Ross (1877 -) tried to incorporate utilitarian and Kantian theories. He does not ignore the consequences but he rejects the idea that happiness or pleasure are identical with rightness; also he does not believe that ethical rules are absolute : such as «Always tell the truth», According to Ross there are actual and «Prima Facie» duties. Often we may not know what is our actual duty. Prima Facie means «at first sight» or «on the sulface». When we confront with more than one prima facie duties, we should act according to our intuitions; we should go along with stronger and more stringent prima facie duties.

Ross lists prima facie duties as follws follows (*) :

1 — Duties of Fidelity : Telling the truth, keeping actual and implicit promises, and not representing fiction as history.

2 — Duties of Reparation : righting the wrongs we have done to others.

3 — Duties of Gratitude : recognizing the services others have done for us.

4 — Duties of Justice : preventing a distribution of pleasure or happiness that is not keeping with the merit of people involved.

(*) Taken from Munson, Ronald : Intervention and Reflexion. 2.nd ed. Wadsorth Publ. Co. Belmint, Cal. 1983.

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5 — Duties of Beneficence : Helping to better the condition of others with respect to virtue, intelligence, or pleasure.

6 — Duites of Self - Improvement; bettering ourselves with respect to virtue or intelligence.

7 — The Duty not to Injure Others. (It is also called principle of Non - Maleficence or **primum non nocere,** namely «above all, or first, do not harm»).

Ross says there are other prima facie duties but the above ones are the most important and have to be accepted by everyone. These duites are also called «Principles» in medical ethics and they are our guides to make our decision as mentioned earlier.

RAWLS' THEORY OF JUSTICE

John Rawls developed the theory of justice in 1971 in which he tried to combine the strenghts of Utilitarian, Kantian and Ross's theories and tried to avoid their weaknesses. Rawls starts with a hypothetical «The original position» and puts the people behind «a veil of ignoranc». By doing this he defends the idea of «justice as fairness». He defends the imposed rules (paternalism) for the good of individuals and society. He puts 1) the duty of justice, 2) the duty of helping others in need and jeopardy, 3) the duty not to harm or injure another (non-maleficence), 4) the duty to keep our promises, as «natural duties». Rawls' «Natural Duties» are same as Ross's «Prima Facie Duties». Rawls tries to assign priorities to duites. He rejects the idea that one group of people should be research subjects for the benefit of other millions of people.

THE TURKISH CODE OF MEDICAL ETHICS

The following principles are excerpts from Tıbbi Deontoloji Tüzüğü of Turkish Medical Association, dated 1960. Turkish code of medical ethics is in accordance with the International ones. It is written for physicians and dentists but in order to avoid repetitions, only the «physician» is mentioned. (See Appendix I. for full text)

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General Principles

Article 2 — The first duty of a physician is to care and respect human life, health and personality, no matter what the sex, race, nationalty, religion or denomination, moral values, character or personality, social status, eductional level and political beliefs.

3 — A physician shall take care of emergency cases no matter what his official duty and his specialty.

4 — A physician cannot reveal the confidentriality of a patient unless he is forced by law.

5 — A patient is free to choose his physician although certain health facilities may have their own rules.

6 — A physician shall always maintain the highest standards of professional conduct and shall act according to his conscience.

7 — A physician shall avoid unethical conduct even in areas other than medical practice to protect the integrity and honor of medicine.

8/9 — Advertistising is not permissible for a physician.

10 — A physician shall not apply new methods before he is fully confident in them.

11 — Human body cannot be used for research before in-vitro and animal studies.

12 — A physician a) cannot perform any procedure on patients to obtain unjust benefit, b) Paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

Principles regarding doctor-patient relations :

13 — A physician cannot be critisized ethically when the illness is not perfectly cured as long as he used all his scientific abilities. Deceptive diagnosis and treatment against medical principles are prohibited.

14 — A physician has to comfort and decrease patient's pain and misery and give hopes to the patient even he cannot cure the illness.

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15 — A physician shall enlighten the society for preventive medicine.

16 — A physician shall certify only that which he has personally verified. (Honesty in report writing.)

17 — A physician shall not interfere with his patient's personal and family affair.

18 — A physician may refuse to take care of a patient for personal and professional reasons except in emergency cases, in official duties and for humane reasons,

19/20 — Placebo may be given in exceptional cases only for consolation if there is no possibility for treatment.

22/23 — Abortion may be permissible to save mother's life only with extreme care.

24/30 — Whenever an examination or treatment is beyond the physician's capacity he should summon another physician who has the necessary ability (Consultations).

31/36 — A physician should go along with the resommendations of Turkish Medical Association for fees.

37 — A physician shall behave toward his colleagues as he would have them behave toward him.

38 — A physician shall not critisize his colleague nor should he belittle them. A physician shall protect his colleague's dignity.

39 — A physician shall not entice patients from his colleagues.

40 — A physician shall not violate the independence of auxiliary medical and paramedical people.

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RIGHTS OF THE PATIENT

Generally the rights and freedom of persons are guarantied by every nation's constitution. Each person has the right to protect his body and saul in the Turkish constitution as well.

Article 17 of the 1982 Turkish Constitution(8) states : «Everybody has the right to protect and improve his physical and moral existence. A person's bodily integrity cannot be violated except for medical necessities and in certain situations described by law; a person cannot be a subject of scientific and medical experimentation without his consent.»

Article 20 states : «Everybody has the right to ask respect for his personal and family life. The confidentiality of personal and family life cannot be violated. Exceptions are preserved for investigations.»

Article 5 of Turkish Medical Ethics Regulation states : «A patient is free to choose his own physician and dentist. Rights are reserved for health services», Article 4 of this same regulations states : «Physicians and dentists cannot reveal the confidentiality of a patient, which they have obtained during their practice, except for legal obligation.» There is no unlimited freedom of persons in any constitution. There are certain limits in every constitution as in ours.

World Medical Association adopted following statement in 1981 as «The Declaration of Lisbon» : (See Appendix III)

a) The patient has the right to choose his physician freely.

b) Patient has the right to be cared by a physician who is free to make clinical and ethical judgements without any outside interference.

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c) The patient has the right to accept or to refuse treatment after receiving adequate information.

d) The patient has the right to expect that his physician will respect the confidential nature of his medical and personal details.

e) The patient has the right to die in dignity.

f) The patient has the right to receive or decline spiritual or moral comfort including the help of a minister of an appropriate religion.

AUTONOMY

Autonomy means self rule or self government. An autonomous person determines his own way of action according to his own plan. When this is applied to medical ethics, it means that the patient has the freedom to choose his own physician; he is free to allow to be treated or not; he is free to accept or refuse a physician's diagnostic or treatment plans; he is free to terminate the treatment at any time he wants. A physician has less rights in this respect; he can refuse to continue to take care of the patient but legally and morally has to give certain time to patient; in some cases he has to help find another physician. If the physician ignores and disregards a patient's rights, he violates legal, ethical and professional responsibilities.

Our moral responsibilities are justified or unjustified according to different ethical theories :

Utilitarian theory sees individual autonomy or self determination from personal point of view. A person is free in his actions as long as he does not interfere with the freedom of others. According to Utilitarian Theory, for instance, if a person's life is in danger or someone is on trial for a serious crime, confidentiality may be violated.

According to **Deontological Theory** every person is a rational and autonomous agent. The person makes decisions on his own life after he receives truthful information from his physician, no matter how painful the truth may be. Immanuel Kant says placebos or doc-

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tor's lies are unethical, and confidentiality should be regarded as absolute. Purely subjective and personal principles are morally unacceptable for Kant. The opposite of autonomy, according to Kant, is «Heteromony», namely rule by other persons or conditions from outside and impulses from inside are frankly heteromonous; we cannot talk about autonomy if these conditions are present.

W.D. Ross states that everyone has a right to decide about his own life and to know the truth and be educated in helpful ways. Ross believes confidentiality is absolute; paternalism and lying are not permissible.

John Rawls gives more rights to the state, which regulates the rules on the kind of the drugs and treatment methods.

Autonomy or self rule has meaning only when it is respected by the physician as far as the medical ethics are concerned. Only in this way a healthy patient-physician relationship develops([5]). In this relationship the patient has the legal and moral authority but the physician has a strong psychological, specialized and technical authority. The patient is weak, fearful and at the mercy of the physician. For this reason the physician should be careful in using his authority. At this point, a physician should carefully show his respect to the patient's sense of self-respect. Otherwise patients distrust physicians and the physician-patient relationship, which is exteremely important in treatment, is disturbed. Patients may become uncooperative in treatment

When the patient and the physician have both accepted each other, it means that the patient has «consented» to procedures, and the doctor has agreed to take care of the patient. Only in this condition can a doctor tauch a patient; otherwise the doctor's examination could legally be interpreted as an assult, like on ordinary man's putting his hands on a person's privates.

PATERNALISM

Untill now we have emphasized the patient's rights. As we said earlier and our Turkish Constitution states, the individual is not completely free. This freedom has some restrictions. The state restricts some personal freedom in order to be beneficial to the patient

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himself and to society. The best explanation of paternalism is «Father knows the best.» In paternalism, the patient's freedom is interfered by reasons referring to the happiness, welfare and interests of the patient. For justifiable reasons, the governmend recommends that patients go to state hospitals or social security hospitals (Devlet Hastaneleri ve Sosyal Sigortalar Kurumu Hastanesi) because either there are not enough private physicians or patients cannot afford to go to private physicians or to private hopsitals. The government allows physicians to prescribe certain drugs after they are carefully experimented by state agencies. The state does not allow treatment by unlicensed medical personel such as faith healers, black magicians etc. The law requires also workers to wear safety helmets, prohibits homosexsual relations, prohibits the use of habit forming substances and prohibits duelling for the welfare of its citizens.

In order to explain paternalism, let us give the example of Laetrile. I heard, read and was indirectly involed in my 25 years pratice in USA with laetrile.

Dr. Ernst Krebs extracted a chemical named Laetrile from apricot pitts in 1920 in California, hoping to improve the taste of illegal whiskey. In 1952 his son purified it and claimed it cured cancer through some enzyme interferences. Several patients started receiving laetrile for a high price, for cancer treatment. Several experiments by many respected goverment and private research centers failed to prove any benefit of laetrile for cancer treatment. Some patients sincerely believed it was helpful; at least no patient said It was harmful. Finally Food and Drug Administration (FDA), a US government agency, prohibited production and importation of laetrile. The product is still made in Mexico. Patients still go to Mexico for treatment and spend millions of dollars for laetrile treatment. Huge associations have developed to defend the autonomy and patients' rights as well as laetrile. They have argued that it could be given, at least, to terminal cancer patients in order to give them some hopes; because the drug has no serious side effects.

Some states in the USA have passed laws to legalize laetrile. The debate continues. The FDA's reason for objecting to the use of laetrile is : Patients neglect scientific and proved cancer treatments which are successful in more than half of the cases, and they waste valuable time and money by undergoing laetrile treatment.

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After all we must accept the power of the mind. Science does not believe in hypnosis, acupuncture, faith healing etc. because these have not been scientifically explained. In the last 20 years science has found some new methods to extract certain substances from metabolites such as Endorphines. The brain produces endorphine which acts like morphine; it induces sleep, it releives pain; by hypnosis or other means doctors can sometimes do painless deliveries of babies and perform surgery without anesthesia relying on these «Natural pain killers.» Also we know but cannot explain that some hopeless cases improve by themselves. This maybe attributed to power of the mind.

This laetrile case is a good example to paternalism. After the laetrile debate, patients' autonomy and individual rights came more into daily discussion; it brought more and more malpractice suits and «the customer protection movement» Maybe recently you noticed in supermarkets and groceries that producers have started putting labels in their products showing ingredients in them. This is a law in the USA now. About 15 years ago, the US FDA required all food manufacturers to put clearly visible labels listing ingrediens in order of their quality on their products. This practice has more recently been applied to cosmetics and over-the-counter drugs.

INFORMED CONSENT

During WW-II the Germans performed many inhumane experiments on prisoners of war in concentration camps. They induced infection in prisoners and tried to treat these with different agents; gave poisons in different doses to test the poison; put them in different atmospheric conditions to try their endurance; they tried genetic and biological experiments such as trying to change prisoner's eye color and to graft skin. Subjects did not receive any information on these experiments and their consent was not obtained. Experimental subjects experienced pain, misery and agony before dying prematurely. Finally in 1947 German physicians involved in these experiments were tried in Nurenberg; 7 of them were hanged and 8 received prison sentences. After these trials a resolution, called **Nurenberg Code**, was passed: after some changes, first the

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Helkinki (1964) and finally **The Tokyo Agreement** (1975) was passed by tne World Medical Assembly. (See Appendices IV, V, XI)

When people became more aware of human rights they asked their rights from medicine, they wanted to know what was going to happen to their bodies. It became more difficult to bring new drugs into the market, because drug tests on humans brought more and more obstacles. Physicians now must give more information about the possible complications during or after treatment and surgery. By this time, especially in the USA informed consent became almost a number one issue in medical ethics.

In the dictionary **consent** means «agreement and acceptance to an act», **informed** means «having or based on information.» **Informed consent** is giving information (to the patient) about the nature of procedures, what good or bad results or effects we can expect after the process, and only after the patient understands and grasps the information, he gives permission to the doctor to do the proposed act. Namely the physician will disclose the information, possible outcomes of an act, then the patient will accept it. In other words, informed consent is a patient's giving permission for a medical intervention with his free will without any pressure, after he is informed by physician about the nature of an intervention, its benefits and risks, and its alternatives. There are 2 elements in **consent**:

1) Voluntary consent

2) Competence of consent

Consent should be voluntary with free will. It should not be with threat of others or force. Competence of consent will be discussed later in detail. It means, the person giving consent must be of legal age, in sound mind and judgment.

The informend part of informed consent also has 2 elements:

1) Disclosure

2) Comprehension

In disclosure, the physician informs the patient the nature and the extent of medical interventions (procedure), its alternatives, its benefits and possible risks and complications and the cost. This means respecting a patient's rights and aotonomy. If a patient

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cannot comprehend the information, the other three elements (competence, voluntariness, disclosure) do not mean anything. A patient generally does not know medicine and he is in stress; he is desperate. He should be told in simple terms and clearly. A patient should be asked whether he really understood what we meant. If necessary, the patient should be given brochures or he should be referred to educational courses.

Informed consent seems a headache to physicians. Doctors say they are already busy; they do not have time to educate the patient. Also they do not want to frighten their patients. It could sound as if we showed our weak points to the opposite side in war. However this analogy is not true in informed consent. We should respect the patient's autonomy, legal and moral rights.

The importance of informed consent is different in emergency and in elective cases. Information may be curtailed in emergency cases. We should be more generous in giving information to elective cases, as well as other elements. But in research, all 4 elements should and must be considered. This will save you from establishing a bad medical reputation and malpractice suits. In American courts, the most frequent question to the physician is «Did you obtain informed consent».

Let us try to explain informed consent with a case;

Case : Mrs. A.T., 32 years old white female, mother of 2 children, ages 6 years old and 8 months old; former teacher. Husband is a PhD chemist, her 70 years old bedridden mother lives with them Mrs. T. developed a depression during the past month. She has a poor appetite, cannot sleep well, has lost some weight; feels down and worthless, thinks she is not a good wife, mother or doughter. She thinks about suicide quite often. The diagnosis is severe neurotic depression with suicidal ideas.

Doctor told (informed) the patient of the diagnosis, prognosis, possible suicide and assured the patient that it is treatable. There are three treatment alternatives : 1) Analytical psychotherapy without any drugs, which takes from 3 to 6 months, costs $ 50 per session, of which 80% is covered by insurance, once a week; but cannot guarantee the cure. 2) Drug therapy; Imipramine 150 mg/day, rather high dose. As side effects she may have dry mouth. con-

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stipation, dizziness, may fall down and injure herself. She should be extremely careful in driving, and may have seizures. She may show improvement in one month. Supportive therapy will be added 1/2 session a week. 3) Electro-shock therapy (ECT) plus drug therapy at the hospital; possibility of bone fractures and danger of anesthesia is mentioned. This last alternative was unsafe but the result was almost guarantied.

She could not afford hospitalization because she could not find somebody to take care of her baby and sick mother. She did not object to psyschoanalysis but it was time consuming and the result was not guarantied. She promised not to drive in heavy trafic and accepted the potential side effects of drug. This therapy is agreed upon by both the patient and the doctor. (Discuss possibilities of suicide, car accident, side effects in patients with glaucoma and coronary heart diseases and possible malpractice suite.)

COMPETENCE

In order to use his freedom, a patient must understand the nature of diagnostic and treatment procedures, he should be in sound mind; his thinking, reasoning and judgment should be reasonably good. Minors, senile people, mentally ill, confused patients, the ones having delirium due to metabolic, toxic and infectious illneses etc. are not competent to give their consent for diagnostic and treatment procedures. Their guardian must sign consent for diagnosis and treatment. This is extremely important in psychotherapy and surgery of incompetent patients. If a guardian is not available and if there is a life threatening situation, the physician goes ahead to treat on the graunds of **Implied Concent.** This means the patient would consent if he were in sound mind. This goes along with «principle of beneficence».

In semi-emergent cases, if a patient is incompetent and there is no guardian, a court order is obtained for any case and a psychiatrist's report is needed for confused cases. This is called **«Proxy Consent»**. Hospital commitee gives consent in hospitalized cases in Turkey for such patients.

If there is danger to self or others such in the cases of mentally ill or infectious illness, a patient may be treated before getting

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consent; this is called **«Statutory Authority to Treat.»** This is not acceptable in some countries.

In certain cases of minors (married and drafted minors are counted as adults) treatment may be applied without a guardian's consent : such as drug abuse cases and venereal disease. Some states accept or reject the consent of minors in contraception, abortion and mental illnesses. A physician should check this through the local chapters of medical associations, chief administration officers, a lawyer or an experienced colleague. In Turkey, hospital committees may give consent for some of them. Eloped, married or drafted minors and students living away from their families in other towns sometimes are accepted as adults. The justification in these cases is that they are already young adults, they have enough reasoning and judgment to live on their own. Therefore medical intervention is taken for their benefit.

Although refusal of the treatment on the grounds of unusual beliefs is not a problem in Turkey, you should have some ideas on this topic. Some people, such as Jehovah's Wittnesses and Christian scientists, believe that drug therapy, organ transplantation or blood transfusion are not permissible by God. Also some people do not accept any drugs except megavitamin therapy or a macrobiotic diet. These people cannot be put into the group of incapacitated. Unusual beliefs should be tolerated if there is no danger to others. If a patient refuses a blood transfusion and the doctor sees a real necessity, the doctor may refuse the patient if he cannot convince him. Even courts in the USA could not decide against their beliefs. However for minors of Jehovah's Wittnesses, court may decide to permit a blood transfusion. In a recent court case in the USA, the court decided to allow the medical team to do just that, in contradiction to the patient's wishes. I believe there are some unusual beliefs in Turkey too. Three years ago a young carpenter broke his leg in an accident. Because he belongs to a conservative religious sect, he refused medical treatment, saying that the only healer was God. It is an unfortunate coincidence that the consulting physician agreed with the patient because he himself belonged to the same sect.

If a patient refuses to give information about himself and his illness, we must respect the patient's rights; people have a right

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to keep their secrets. For ethical reasons, a physician has to spend some time with patients to explain why he needs information. If patient still insists, the physician should try to find other ways to establish his diagnosis. This becomes particularly important in giving blood or serving as a volunteer for artificial insemination. There have been reports of innocent victims who contracted AIDS because blood donated by man who was in a high risk group for AIDS (e.g. homosexual, drug user) who refused to divulge this information.

THE THERAPEUTIC PRIVILEGE

The therapeutic privilege is a physician's right to withold information in order to be beneficial to a patient. The physician may think that a patient could refuse treatment if he reveals the risks of procedure and the patient is frightened. Valuable time may pass and the patient may either die or go into irreversible coma or demage. After all, even the simplest procedure, such as injection, or very common medication like aspirin could be dangerous. Therapeutic privilege is a kind of tool for the doctor to save himself from a malpractice suit. It may be an excuse. In the past, judges used to accept this excuse, but recently the courts are not too sympathetic to physicians in therapeutic privileges in USA.

Also physicians use this privilege to cover their ignorance. I noticed that if a person does not know the answer and he is too stubborn, he says : «I thought so; this is my opinion.»

INFORMED CONSENT AND RESEARCH

Research in medicine is done : 1) To learn the cause, the nature and the pathology of illnesses and, 2) to find better ways for prevention and treatment of illnesses. For instance, to find the cause, prevention, nature and the communicability and cure of AIDS, mental, physical and communicable diseases.

Untill the end of WW-II, as described earlier, rules and regulations on research were not well defined, brutal handling and tortures in medical research on human body in concentration camps were on trial after the war.

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There is a risk in every experiment, but in order to be beneficial to human beings we have to have experiments. Two words in this sentence, **risk** and **benefit** are the main factors. When we do an experiment we will ask this question: «Should we take certain risks to obtain certain benefits?» The risk-benefit issue is essential in almost every aspect of human life. Risk - benefit issue is present almost in all our decisions. A merchant takes some risks to make money. But the physician encounters this more frequently than other professions.

Sometimes the risks could be great, but we also believe that there is no other way to save the patient's life. For instance Pasteur developed a theory to treat hydrophobia with a live virus. It is still unthinkable to give a live virus like a hydrophobia (Rabies) virus to a human being. But Pasteur knew that a hydrophobic would die anyway. After he informed the parents of the child and got their consent he gave the live virus and cured the child.

There are many kinds of experiments. In each kind of experiment we come face to face with ethics. There is benefit to humanity on one side and our own conscience on the other. According to **Utilitarian Theory** (Mill and Bentham), experiments in human beings are approved; we can sacrifice a few for the benefit of many people; Informed consent is not absolute as long as experimental subjects are paid for risks and sufferings. For utilitarianism, the best subjects for research are less valuable members of society such as retarded, habitual criminals and dying people. Of course it becomes an ethical crisis to decide who is «less valuable» to a given society.

According to **Kant**, research subjects must be rational and autonomous to give consent; experiments cannot be performed on a person if he is not able to understand the nature, aims, risks and benefits of the experiment. Informed consent is a must in Kantian theory.

Ross's theory emphasizes the duty of the researcher to his patient and is similar to Kant's. Both Kant and Ross believe that research in human beings cannot be based on what is useful but is based on what is right.

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Before going further it will be proper to summarize the latest revised criteria of World Medical Association for research on human beings. (Taken form the declaration of Helsinki, 1964, 1983 in summary form.)

DECLARATION OF HELSINKI ON RESEARCH (*)

Introduction :

It is a mission of the physician to safeguard the health of people. The Declaration of Geneva binds doctors with the words «The health of my patient will be my first consideration» and international code of medical ethics declares that «any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.»

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

I — Basic Principles :

1) Research on humans should be in accordance with scientific principles after successful laboratory and animal experiments have been completed and a thorough knowledge of the literature is obtained.

2) Design and performance of the experiment should be approved by a commitee.

3) Biomedical research should be conducted by a qualified person under supervision. The researcher must assume the responsibilities.

4) Importance of the goal should be in proportion to the inherent risks.

5) First the risk and benefits must be carefully assessed. Interests of the subject must always prevail over the interests of science and society.

6) A research subject's integrity and privacy must always be

(*) See Appendix IV for full tex.

respected. To harm to pnysical and mental integrity of the subject must be minimized.

7) Expected dangers should be predictable. Research should be seized if hazards are found to overweight the potential benefits.

8) The doctor is obliged to publish only the accurate results.

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. Subject must be informed that he has the liberty to abstain or withdraw from participation in the study at any time. The doctor should then obtain the subject's freely given informed consent, preferably in writing.

10) When a subject is dependent on research in any way, informed consent should be obtained by another independent doctor who is not related to the research.

11) In cases of legal incompetence, informed consent should be obtained from the legal guardian in accordance with state law.

12) The research protocol should always contain a statement of the ethical considerations and be in accordance with this declaration.

II — Medical research combined with professional care (Clinical research) :

1) In the treatment of sick persons, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgment 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.

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

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

5) If the doctor 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 commitee.

6) The doctor can combine medical research with professional care, the object being the acquisition of new medical knowlege, only to the extent that the medical research is justified by its potential diagnostic and therapeutic value for the patient.

III — Non-therapeutic biomedical research involving human subjects (Non-clinical biomedical research)

1) In the pure scientific application of medical research carried out on a human being, it is the duty of the doctor 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 their judgement it may be harmful to the individual if continued.

4) In research in men, the interests of science and society should never take precedence over consideration related to the well-being of the subject.

USE OF HUMAN FETUSES IN RESEARCH

Some research can be done only on human cells. There are many experiments using in-utero and newborn babies such as chromosome studies, fetal development, some immunologic and vaccine studies and the study of some viruses. Research with human fe-

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tuses creates an ethical problem. An advisory group in England has unconditionally rejected experiments in living in-utero fetus even though abortion is decided. It has recommended that **research be done on living but non-viable fetuses.** Research can not be done on newborn live babies weighing over 300 grams. However, (in some countries) in-utero choromosome studies in amniotic fluid to detect certain genetic studies may be done more freely; it is different than the studies on fetuses.

After debates and court rulings in the US, a law passed on this subject. According to this law experiments in temporarily alive newborn babies and in-utero fetuses may be done; but this same law prohibits government financed research that would either kill an aborted fetus or keep it alive artificially.

THE QUESTION OF AUTONOMY AND INFORMED CONSENT IN PSYCHOSURGERY AND IN BEHAVIOR CONTROL THERAPIS

All kinds of psychotherapies are designed to change, more or less, the patient's behavior. Some of them such as psychosurgery, behavior therapy, hypnosis, Delgado's Electric Stimulation of Behavior, chemotherapy, convulsive therapies cause considerable changes in the human behavior. Ethical issues arise in the above therapies because autonomy of the patient is violated; in some of them, person becomes like «robot» or «zombie». Besides, the imformed consent in these cases is questionable.

PSYCHOSURGERY is any form of brain surgery to relieve mental illness or uncontrolable behavior. Psychosurgery was first introduced by Egas Moniz who cut tha nerve fibers between frontal and prefrontal lobes which is called **lobotomy** to treat mental illnesses. Moniz was awarded Nobel Prize in 1949 for his work. Later other technics were developed such as **Talamectomy, Cingulutractomy, Amygdalotomy** by demaging certain parts of the brain by surgery, elecctro or chemo-coagulation, ionizing radiation or cryogenic methods to treat schizophrenia, severe depressions, obsessive-compulsive neuroses, uncontrolled aggressiveness and psychomotor epilessies. At this time still we do not know how and why psychosurgery is helpful in severe mental illnessses. Psychosurgery is res-

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tricted in the USA and prohibited in the USSR and Holland because of the unreliability and unknown mechanism of the treatment.

The first criticism to psychosurgery is generally that the results are not reliable. Sometimes surgery may create undesirable end results. The patient may loose all his previously gained skills, may forget his learning, so he has to start reading, writing, his trades such as carpentering etc. He may become like a robot, he can not use his own initiative. This means that we take away the patient's autonomy and personal worth. Another ethical problem arises in this respect is the one that the results of surgery is irreversible, there is no possibility to return to previous behavior (personality).

Other important ethical question in psychosurgery is informed consent. If the patient is severely mentally ill, he or she cannot give informed consent. Are parents, next of kin, a court or a board eligible to give consent? Yes, they are. But they give the consent according to their own criterium. Somebody else uses the right of the patient; their criterium is so called «normal behavior» or «the socially acceptable one». We are not sure either the patient himself really wants to change his behavior. How somebody else could decide for the patient's best interest? Recently psychosurgery is mostly performed for aggressive criminals and sexual deviants. How sincere are the candidates to give the informed consent? Patient's motivation may be to get out of prison or detention.

BEHAVIOR CONTROL THERAPY of Skinner or others developed in 1960s and early 1970s on the grounds of conditioned reflex and learing theories. With Skinner's Operant Conditioning technics (aversion and rewards) alcoholics, smokers, drug addicts, homosexuals, criminal psychopaths, phobias and obsesive - compulsive neurosis and children's undesirable behavior were succesfully treated. For instance an electric shock is given to a homosexual man while he was watching nude male pictures and rewards are given while he was watcing nude female pictures.

Behaviorists believe that all our behavior is the result of conditioning.

Behavior control technics of Skinner and others are also ethically questionable because therapist «controls», «conditions» or «modifies» the patient's behavior. These acts mean to take away or

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at least restrict the patient's autonomy and freedom. Especially in avertion therapy rather severe hardship is given to patient, such as electric shock and unpleasant pictures or memories. However, every psychotherapy interferes, more or less, with the patient's freedom; one way or other therapist imposes his own behavior upon the patient. After all most of the treatment in medicine is painful as surgery, bitter drugs etc. There is pain of shock in aversion therapy and fractures in classical electroshock therapy.

Another criticism to behavior therapies is that if it is applied to the majority of society by an evil therapist, what could happen to that society? You could imagine an able but evil therapist could impose his own ideals to society to create a dictatorship. However this is the remotest possibility. In fact, every psychotherapy maybe abused by therapist if he or she wants it. Good use and abuse are important. Law, colleagues or society will not permit the abuse.

BEHAVIOR CHANGING DRUGS : Toward the end of 11.th century Hasan Sabbah in Iran established a religious sect and assassinated his enemies by his men who were given Hashish in order to obey Hasan's orders. They are called Hashishin and the word of Assasination comes from this practice. In my village there is a plant which is called «deli otu»; if someone chews its seeds person shows different signs of schizophrenia.

Lafayette Clinic in Detroit, where I worked, in early 1960s extracted a heat sensitive protein from the serum of schizophrenic patients. When this protein is injected into the veins of volunteers, they showed schizophrenic symptoms exactly as the original patient. In the following years Lafayette Clinic found several different heat sensitive proteins. Lafayette people claim that they could make you whatever character you want with these proteins; if you want to be the bravest person in the world, you got; if you want to be a submissive man, they can make you so, etc. However, the effect of the injection is temporary, next day you regain your own old character. Food and Drug Administration of the USA did not allow Lafayette Clinic to market their products, possibly due to the fear of their being used for illegal and political purposes.

ELECTRICAL STIMULATION OF THE BRAIN : In 1964 Jose M.R. Delgado implanted electrodes into the brain of animals together with a miniature radio in the head. He controlled the behavior of

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animal with a remote control device. Delgado was able to stop a raged bull by pushing a button and made it to walk away by pushing another button. He was able to control a chimpanzee's behavior by a computer. He was able to make an animal to open and close its eyes, to sleep or wake up, to sexually arise and other acts. Delgado's method is presently applied to human being to handle the uncontrollable behavior of psychomotor epileptics. The time is early to discuss the ethical aspects of Delgado's method because its limited application to human beings. However same ethical principles may be applied as in the behavior control method as mentioned above. Controlling behavior by implanting an electrode into the brain should not be greatly different than implanting an idea in behavior control technic.

HYPNOSIS : With the help of certain technics, a person is hypnotized, he loses his freedom and he is under the control of the hypnotist. If the hypnotist abuses his profession, hypnotized person may even kill the people with the post-hypnotic suggestion. Here again the benefit of hypnosis depends to the good will or abuse of the hypnotist.

Hypnosis is like a double edged sword. Sometimes hypnotist can not control the person anymore; the latent emotional disorders, psychotic tendencies may come out and person becomes a full blown psychotic. That is why the use of hypnosis in therapy is limited because of above possibilities.

BRAIN WASHING, PROPAGANDA AND ADVERTISEMENT : Although these do not directly relate to medical ethics, it will be good to mention them very shortly here as the psychological control of masses. With certain methods, group of people may be strongly influenced by the organizer for political and religious purposes. Brain washing technics are related with conditioning reflexes, learning theory and behavior modification.

Possibly propaganda and advertisement in news media may be classified as brain washing.

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TRUTH TELLING

I am sure most of you, as I did, sometimes have wanted to know how long you will live. But when we sincerely think about it, we do not want to know it. Suppose you know you are going to die in 6 months. How should you feel about it? What are you going to do in those 6 months? When you think more about it, you will see the fact that the important issue is quality of life, not the quantity. We want to live long but not in misery. We want to live in dignity, in honesty, in respect, with as little as mental and physical pain and misery. As Benjamin Franklin said, «All would live long but never grow old.»

On one side we believe that every patient has the right to know what is wrong with his body and what condition it is in. On the other side we also believe that telling the truth to the patient will harm him. For instance, if you tell the patient that he has an incurable illness and will die in 3 months, you risk the possibility of a depression, a heart attack or a suicide by the patient.

The doctor is a scientist and also a human being. He believes that lying is a dishonest act. Knowing the time of death seems agaist the nature and God. In Islam and, for that matter, in most organized religions the belief is that only God knows when we will die. So it would not be good to play God by telling the patient when you think he will die.

In our previous lectures, several times, we impressed the fact that the patient and the doctor should be honest with each other; the doctor should tell the truth to his paient in order to establish a good physician-patient relationship. Deception, namely, telling what is untrue or omitting the truth is unethical in our culture and in almost every religion.

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Generally physicians are ambivalent about giving hopeless outcomes to patients. During the last 20-30 years in western medicine there has been a tendency to believe that patints have the right to know the truth. The argument of telling the truth to the patient has gone on since the beginning of medicine. The physician is cornered, left alone with his conscience to decide what to do. Proponents of telling the truth say that «truh is brutal but telling it should not be». They believe telling the truth is a moral duty; the patient may need the truth to make his plans; hiding the truth may harm patient-doctor relationship and harms the doctor's reputation. They believe that patients do not get upset when they hear the bad news, contrary to most people's beliefs; it is the physician's anxiety that causes him to hide the truth because it is difficult to keep the bad news. Laws in the US, like ours, permit doctors to withould the bad news; recently this right has been curtailed by the courts.

Proponents of not telling the truth about bad outcomes, namely lying to them, say that lying is unethical and undesirable for politicians, lawyers and other professionals but not to physicians in this matter, because the main goal of the physician is to maintain and even bolster the hope of the patient. Two main principles in medicine are: 1 — Doing beneficence, 2 — not doing harm-non maleficence. When we lie and do not tell the truth to patients with a bad prognosis, in most cases, we do not harm the patient, but we give him hopes to spend even his short life in comfort. Hope is one of the greatest gifts given by God to human beings.

The first reaction of patients to a bad prognosis, mostly, is denial. They do not believe in the doctor; they ask the diagnostic tests to be repeated or go from doctor to doctor. Then they become mentally depressed. After awhile they become indifferent, almost schizophrenic in some cases. In such a mental state, many of them are unable to make good plans regarding their business and family affairs.

Defenders of not telling the truth to patients give the following justification for their beliefs : 1) No matter how much the science improved in diagnosis, we cannot be 100% sure. After all, every person's response to a given disease varies. There are patients who live, even when we thought there was no hope. Others die when we were not expecting it. After all what was an incurable or hope-

less illness 30-40 years ago, such as subacute endocarditis, pernicious anemia, tuberculosis, syphilis etc., now are treatable. Kidney deficiency was hopeless; now we transplant a new kidney and the patient lives hapily. 2) Some studies have shown that actually patients do not want to know bad news. Patients always want to obtain hope and good news. 3) Telling the truth may harm the patient as we mentioned earlier. Most patients become depressed. Some of them have cardiac arrests, some of them commit suicide when they are told that they have an incurable disease. The physician's duty is to make patients feel as comfortable and happy as possible until they die.

Hippocratic and other oaths and codes do not mention truth telling. Turkish Medical Ethics Regulation says in this respect (Article 14): «Physicians and dentists should give hopes to patients. If they believe bad news on prognosis do not worsen their patient's condition, they should tell the truth openly on diagnosis in order to take proper precautions. However, physicians should not tell the grave outcome and prognosis to their patients. A bad prognosis maybe hinted with great precaution Such a prognosis may be revealed to a patient's family if the patient did not ask not to be revealed or he did not determine the person to be revealed.»

In hopeless cases the attitudes of the physician and the people around him are important. Some research has shown that truth telling bothers the physician more than the patient. The doctor is uneasy about keeping secrets and does not like to take responsibility of its consequences. Some studies. have shown that already most patients sensed their outcome; they knew more than we thought. If a doctor abandons his hopeless case, the patient feels left out, isolated and emotionally deprived in addition to his physical pain. A study[56] among doctors, done by Dr. Donald Oken in 1961 showed that 80% of physicians did not want to tell the truth, only 12% did so.

The physician, family members, and other helpers either take an indifferent attitude or show excess pampering to hopeless cases. They are both worng. All these people should treat the patient as before; as if nothing has happened.

Secrecy creates anxiety in a patient. Vernick and Carron[94] observed in their study in a leukemia ward that most children knew

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their grave outcome. When hospital staff changed their attitude of protection and secrecy, children were more comfortable about expressing their fears and concerns; they were not afraid of death as before, nor as much as the medical team had assumed they would.

Elizabeth Kübler-Ross[40], on telling the truth to cancer patients, not necessarily hopeless cases, says : «If a doctor can speak freely with his patients about the diagnosis of malignancy without equating it necessarily with impending death he will do a geat service to the patient. He should at the same time leave the door open for hope, namely, new drugs, treatment, chances of new technique and research. The main thing is that he communicates to the patient that all is not lost; that he is not giving him up because of a certain diagnosis; that is a battle they are going to fight together (patient, family and doctor) no matter the end result. Such a patient will not fear isolation, deceit, rejection, but will continue to have confidence in the honesty of his physician.»

There are some cases in which it is better to tell the truth. For instance, a 20 year old girl who is diagnosed with incurable cancer or genetic disorder should be told diagnosis to avoid an unhappy marriage.

In some cases the bad prognosis may be given if it is going to cause great harm to family finances or important decisions. But it should be told tactfully and by taking time after realistic considerations. In these cases it is better to consult with experienced colleagues and lawyers. As in every aspect of his life, the physician should use his best judgment, his empathic skills and his conscience. The physician should carry an imaginary scale in his hand all the time. He should ask «If I were the patient, what would I want?»

If we intend to tell the truth to a patient we have to know about patient's age, education, family make-up, financial responsibilities, and most important, his intelligence, sensitivity and mental stability and religious beliefs. A mentally unstable person cannot take such bad news; they are the ones who commit suicide or have cardiac arrest when they hear a hopeless outcome. The reason for committing suicide in these cases is not necessarily fear of death; it is fear of pain and agony; they want to suffer as short as possible and experience death as easily as possible.

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If a hopeless patient insists on the truth, tell him only God knows about it, everybody's reaction to certain illness is different, that it is advisable to make last wills as early as possible, because a very healthy person could be killed in a traffic accident the next hour. Patient's questions about the length of his life may be answered with a questin; why he wants to know? What will he do if he knew when he will die? By doing this we can analyze the patien:, take time, and gradually he himself becomes aware of the situation. A devoted Moslem will not ask you when he will die because he already believed that only God knows when he will die.

PLACEBO

In Latin, placebo means «I will please», Placebo may be a ritual, a touch, an incision, an inert material such as sugar or chalk or a mixture of plants and herbs. Namely the doctor gives a substance or applies other external things to a patient in which the doctor knows there is no effect, but the patient believes it is a real treatment. A placebo is used in the guise of a drug to please the patient. A placebo may cure or help through the patient's suggestibility, i.e. the patient believes that the placebo will cure him.

Charles F. George(*) defines placebo as follows :

1 — A treatment, given to please the patient, which has a psyhological rather than physical effect.

2 — A dummy substance, e.g. tablet or capsulle, used in comparision with a potentially active treatment in a clinical trial.

Is placebo use contrary to medical ethics? Not necessarily so. There are certain patients who are hypochondriacal, namely they imagine an illness when in reality they do not have any illness. They go from doctor to doctor. They are given a placebo which helps for awhile, then they go to another doctor. It is ethical to give a placebo to such patients. Some people, especially after surgery are given morphine or other pain killers to ease their pain. They like its effect; several days later they ask for it for little or no pain. To give

(*) George, Charles F.: Placebo, at Dictionary of Medical Ethics Pp 329 - 30, Darton, Longman and Todd. London, 1981.

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a saline solution to them pretending it is a pain shot may relieve their pain. In drug addicts a placebo is given to replace the addicted material (opiates, barbiturates etc.); but they have withdrowal effects, this is dangerous. Placebos may also be beneficial to dying and incurable patients. Toxic substances should never be used as placebo.

Two basic principles of medicine can be applied to justify placebo use :

1 — Do good - Beneficence, 2 — Do not harm-Non-maleficence.

In clinical drug research, we give a drug that has previously been tested with animals to half of the patients and a placebo to the other half. This may be deceptive but it is ethical. Patients should, however, be told that they may be on the drug or the placebo regimen. The researcher will not know which it is untill the code is broken.

If a charlatan physician gives «pink pills» for premenstrual tension or for beauty or gives saline solution as «booster shots» to make the patient strong by saying that they are rare and very expensive imported medicine, this is unethical. In this case there is no benefit to the patient and the doctor does this to get monetary benefit and to keep taking advantage of the patient. This is called Quackery. If a surgeon cuts only the skin by making the patient believe that this is for appendicitis, this is unethical and quackery. Faith healing and acupuncture are said to be placebos too, but recent discoveries have shown that they have an effect in different ways. It is hard to call them unethical; in these cases the therapist sincerely believes this is a right treatment and the patient benefits from it.

Placebo effects could not be obtained in animals, it is unique for humans. We would conclude from this that the placebo effect is explained psychologically Some patients feel relieved of their pains and misery even by examination or by sensitivity testing with needles. These people are strong believers; they can be helped by whatever an authoritarian physician does. It is believed that placebo effect is obtained by the release of opiate-like substances (endorphines and enkephalines) within the brain

Possibly the placebo effect comes from our infancy. When a baby is hugry, the mother gives pacifier and the baby stops crying for awhile, sensing that he is fed. This becomes unconscious; in later life placebo shows its effects through unconscious relationship.

Negative placebo effects could happen either, 1) by using potential substances with medicinal intent or, 2) the patient insists on a medication and the doctor believes that there is no illness. However, if he tells the patient that his illness is imaginary, this may hurt the patient and he may seek an another doctor. In this case giving a placebo is indicated, providing that the doctor should tell the patient that this is a trial medication. If there is no help in a few days, the placebo should be discontinued or changed. This is still better than giving a potent and harmful medication. Physician could be ruined if the patient learns of the deception. Negative placebo responses may account for some of the adverse side effects observed when potent substances are admisinstered with medicinal intent.

Here is an example to placebo effect: When I was little, there was a famous and legendary physician in my home town. An old man went to him for an illness. After doctor examined him, he wrote a prescription and told the patient: «Mix the components of this prescriptions with water, then drink it 3 times a day before meals.» The patient came home, he put the prescritpion paper into a glass of water, mixed it carefully and drank one tablespoon before the meals. His illness is cured in couple of days. Some other time he again went to the same doctor and thanked him that his prescription was wonderful, he told how he mixed the prescription paper with water to the doctor.

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CONFIDENTIALITY

(PROFESSIONAL SECRECY OR PRIVILEGED COMMUNICATION)

Confidentiality is the oldest and one of the most important ethical prpblems in medicine. Patient tells very personal matters to his physician in order to help reach a correct diagnosis and treatment. One of the prime duties of a physician is to keep the secrets of the patient. The physician wants all the details about the patient in attempt to diagnose and to provide treatment. Because the patient knows this fact, he tells his personal and family secrets to the doctor. The physician also learns some secrets on examination about his patient and his family and home. Sometimes these secrets could ruin the patient and his family if they were to be revealed. Suppose you diagnosed a serious illness in a powerful head of state; what would happen to the nation's politics and economy if you revealed it? It could even effect world policies. When Eisenhover had a heart attack, the stock exchange dropped seriously; billions of dollars were lost in two days. The same thing happened when President Johnson had a gall bladder surgery.

Suppose a patient told you he was going to kill a certain person. Are you going to keep your promise and not warn the victim? Or are you going to inform the victim or police and break your promise and oath?

The Hippocratic Oath says : «In connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such be kept secret.»

The International Medical Oath says : «I will respect the secrets which are confided in me, even after the patient has died.»

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Article 20 of Turkish Constitution says: «Everybody has the right to ask respect for his personal and family life. The confidentiality of personal and family life cannot be violated. Exception are preserved for investigations.» Article 198 of Turkish Criminal Law says: «If a person reveals confidentiality which is obtained during duty and which is going to harm that person who confided and if he cannot find a legitimate reason to reveal it, is punishable with jail up to 3 months and fine.» Article 235 of the same law also says a government employee has to reveal confidentiality when this act has to be investigated. Article 530 says medical personnel must report criminal acts done upon the victim to authorities.

My own Case: In 1970 a psychotherapist, a former subordinate of mine, reported to me that a certain patient of hers was going to kill me. She was in stress due to revealing her patient's secret. About one month prior to this I was called by the local prosecuting attorney to examine and write a report on a potentially suicidal case in hospital emergency room. After my examination I believed he was very depressed and suicidal I wrote my report to commit him to a psychiatric hospital for detention and treatment. The hospital discharged him in 3 days because they did not believe that the patient was suicidal. The patient developed a hostility toward me; he was trying to find a proper time and place to kill me. I asked police protection which was denied because, according to Michigan law they could not do anything to him until he killed me. I asked for permission to purchase a gun which was also denied by the prosecuting attorney because he believed my gun could be dangerous to me, and the patient had a report from the hospital that he was not dangerous. A few days later a neighbour saw that the patient was walking in the woods around my office carrying a gun. My complaints to authorities were not helpful. I took some precautions but I was afraid. About one week later I read in the local newspaper this man had committed suicide with the same gun by blowing his head. I felt sorry for the man but I was relieved, as if a new life had been granted to me.

When I presented my case in a medical meeting, most colleagues agreed with the therapist who violated privileged communication but still there were old fashioned colleagues who said confidentiality was strict. the Hippocratic Oath was clear, and even

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the fact that my life was in danger did not give the therapist the right to break this aoth.

In 1975 a California court ruled againt a college psychotherapist who did not warn the victim (Tarasoff Case). The patient told the therapist that he was going to kill Ms. Tarasoff. The therapist reported this to campus police who arrested and then released the patient because police believed the patient was in sound mind. But one month later the patient killed Ms. Tarasoff.

Article 4 of Medical Ethics Regulation of Turkish Medical Association says: «Physicians and Dentists cannot reveal confidentiality unless they are forced by law.» I believe this article needs some revision. Neither this regulation nor article 198, 235 or 530 of the Turkish Criminal Law will give the therapist the right to reveal the harmful intentions of the patient. However, legal tradition in Turkey is more reasonable: «Small benefits may be sacrificed for bigger ones» it says. I do not believe any judge in Turkey punishes a doctor who reveals a patient's malicious intent to kill somebody.

The tradition in Turkish jurisdiction is: «1 — Violation of confidentiality may not be punished if it is not going to harm the owner of secret, 2 — Even in the presence of harm the disclosure of confidentiality may not be punished when confidentiality necessitates a legitimate interest in order to prevent this interest. Namely when there is a legitimate reason, the discolosure may be permissible.» Jonsen et. al.[50] says: «In principle, the well-founded expectation or serious harm to another specific party (not others in general) is the most justifiable reason to breach confidentiality.» For instance, you may diagnose an early stage of heart attack in an elderly man who is planning a long trip. He plans to drive the car and does not want his wife to know about his potentially fatal condition. If you cannot reason with the patient, you may reveal the information to his wife because his wife's life is in danger.

Suppose you diagnosed AIDS in your patient. Are you going to keep quite in order to avoid your patient's shame or are you going to report it to authorities to save hundreds of people from contamination? AIDS is new and laws still have not passed on it, but infectious illnesses must be revealed to public health authorities. To report infectious illnesses is a legal obligation. Especially before antibiotics, some infectious diseases were very dangerous and

deadly. Almost every nation has a quarantine law. If a person or group of persons are diagnosed with the plague, cholera etc. they are taken into observation and kept detained for a period of time. Some immunization shots are obligatory such as smallpox. In these situations, in addition to revealing the secrecy, we detain patients and give them shots, no matter whether they want them or not. Umumi Hıfzıssıhha Kanunu tells what kind of infectious diseases should be reported (Articles 57, 58, 59, 77, 98, 103-127). These examples give us an idea to make a rule :

1) If the secret is going to harm others and society, confidentiality should be broken,

2) Also if the patient gives you permission to reveal his illness, it can be revealed to designated people or organizations, providing that the doctor remains careful about how much and what to reveal. The permitted disclosure could be for insurance companies, impartial examination, marriage, military etc.

What kind of information is confidential and what is not? There is no clear cut demarcation. That is why confidentiality is discussed so much in detail; it is an unending debate in medicine. Certainly the developments in science and society may force our old traditions. In your practice, especially if you are giving psychoterapy and working for the government, for insurance and other companies confidentiality will bother your judgement and conscience everytime

World Med. Assn.(1973) affirms the vital importance of medical secrecy to protect the privacy of the patient (See App. VI)

The situations in which confidentiality may be revealed :

1 — When a patient is going to be seriously harmful to himself and to others. In these cases if the secret is kept, harm is imminent.
2 — To reveal (report) certain infectious illnesses.
3 — If a patient gives you, written or vebal, consent.
4 — Child abuse.
5 — Already known facts such as lameness, blindness, baldness or the ones that the public does not pay attention

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to, such as trafic accidents. However, if a patient still wants, they should be kept confidential.

6 — In the courts, if a physician is an expert witness or an independent examiner, he may report whatever he knows; however, a physician should warn the patient before examination. If the court calls you as an ordinary witness, you can insist about privileged communication and not reveal confidentiality. If a patient gives permission to the doctor to reveal a confidence, the doctor may feel free to report.

7 — There is no confidentiality when a patient asks you to write a report in order to get a job, to marry, to go for special medical treatment within the country or abroad.

8 — A physician may not reveal privileged communication in court in order to collect unpaid fees. However, a doctor may reveal such secrets if a patient sues him for malpractice, or if he is blamed for a patient's death.

9 — Confidentiality may be revealed if it is going to help the patient. For instance it is necessary to tell other doctors treating the patient that the patient is allergic to certain substances.

10 — Doctors should report some injuries of a patient according to Turkish Criminal Law, such as criminal poisoning and assualts. In these cases the confidentiality belongs to someone else, not to the patient. If a doctor does not report the assualtive injury to authorities, he may be fined. However, if a patient does not want his secret to be revealed for good reasons (e.g. father may not want it known that his son has been sexually abused), this should be kept secret. Also the doctor does not have to report injuries if the assailant brings the victim for treatment.

11 — In addition to malpractics suits, a doctor is free to reveal confidentiality if a petient claims that the doctor's report is a fake.

12 — The most difficult decision is to do when you keep your patient's confidentiality in case your country is occupied.

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Unfortunately international organizations could not do anything about this matter more than a recommendation. Traditionally, we should protect a patient's confidentiality in war to the expense of our own life. It is up to doctor's personality. The same thing is true during a period of terrorism in which you may be asked to treat a terrorist. As a physician you cannot reject to perform medical treatment; but what about reporting it or what to do if you are questioned by police? It is again up to your conscience and courage.

When a patient asks you to transfer his records to another physician, you have to transfer them after the patient signs a consent form. From then on, it is the second therapist's responsibility to maintain confidentiality; you will still keep your promise.

Case : A patient of mine asked me to transfer her charts to another therapist. This colleague saw in my notes that patient had told me she had had extra-marital affairs. When the therapist discussed this with the patient herself, she was furious. She put her complaints againt me to the local medical association. The ethics commitee did not even ask me about it, saying that it was the second therapist's responsibility to keep confidentiality not mine. From then on I wrote serious secrets in Turkish in my charts.

Starting around 1978 insurance companies in the USA started to check hospital and office charts to be sure that the therapist had really seen the patient; otherwise they would not pay. Court rulings in this matter were not clear. Nevertheless patients did not object to the insurance company's checking their charts because the insurance companies did not pay for doctors' sevices without seeing the chart. This really bothered me as it did other colleagues. An older Turkish psychiatrist wrote his notes in Turkish with Arabic letters. This was acceptable by insurance company because they really wanted to know that you had given services to the patient.

When the patient dies, confidentiality still continues; but when doctor dies, confidentiality ends. However, legally your family has to reveal your notes if a court or insurance company wants it. For this reason it is better for your family to burn all your records in Turkey after your death In Michigan state you have to keep your

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record at least 7 years; then you can distroy them. This 7 years applies even after you have died.

Do not forget that abortion (especially in unmarried woman), hymen restoration, drug addiction, mental illness, veneral diseases, aberrant sexual preferences and extramarital affairs are strictly confidential

THE USE OF COMPUTERS IN MEDICINE :

It is said that computers brought in second industrial revolution They were applied in medicine too, first for statistical and epidemiological studies, then for diagnosis, prognosis and treatment. You can feed all personal and family history, complaints, symptoms, clinical and laboratory findings and treatment into the computer. When new data comes, you may add them to same disk. In some centers almost all patient files are transmitted into the computers. By pushing certain keys, you can obtain the specific knowledge on patient in a glance. With the aid of other computer centers you may correlate, for instance, demographic cigarette smoking and cancer incidents with correct statistical results. You could avoid genetically transmitted diseases by computer help. You could easily study cause and effect relationship between lung cancer and cigarette smoking or other drinks, food or environmental conditions. In one study doughters of mothers who took diethylstilbesterol some 20 or more years ago have a higher than avarage incidence of adenocarcinoma of the vagina.

However, computers brought several problems together with their great help, especially in the area of confidentiality. If a malicious person is able to reach the computer information, you can imagine how easily and how much harm he may cause.

Medicine was uneasy and hesitant to use computers when they came into the market. You can find these discussions in daily news and scientific publication quite often.

Different organizations brought out regulations on computer applications. World Health Assembly made a ruling in 1973 in Munich and amended it in 1983 in Venice as follows : (See also Appendix VII).

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1) National medical associations should take all possible steps to ensure the privacy, the security and confidentiality of information on their patients;

2) It is not a breach of confidentiality to release or transfer confidential health care information required for the purpose of conducting scientific research, management audits, financial audits, program evaluations, or similar studies, provided the information released does not identify, directly or indirectly, any individual patient in any report of such research, audit or evaluation, or otherwise disclose patient dentities in any manner;

3) National Medical Associations should oppose any effort to enact legislation in electronic data processing which could endenger and undermine the right of patient to privacy, security and confidentiality. Effective safeguards against unauthorized use or retransmission of social security numbers and other personal information must be assured before such information enters the computer;

4) Medical data banks should never be linked to other central data banks.

The resolution of Europen Union of General Practitioners is as follows :

1) The permission of both the patient and his doctor should have been obtained.

2) The patient should be able to obtain information on the nature and the implications of the data recorded about him, but that such information should only be transmitted through the doctor who supplied the data or, where appropriate, the doctor who is treating him.

3) The patient in agreement with his doctor, should be able to correct or delete information appearing on the record.

4) Safeguards should be applied to prevent abuse of the information or access by unauthorized persons.

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5) All personal information of a medical nature should be kept seperate from other types of information accessible to persons other than the doctor.

6) That the responsibility for the use of computerized medical data-system should rest exclusively with doctors.

Note : Both of the above resolutions were taken from «The Handbook of Medical Ethics BMA, 1984.

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ETHICAL ASPECTS OF SUICIDE

If we are autonomous and have all the rights to our body, do we have the right to kill ourselves? Do we have any authority to dispose of any part or the whole of our body? These are the questions human beings have asked themselves since the first man appeared on earth.

According to statistics, suicide is the 10.th most frequent cause of death in the USA; 20.000 people kill themselves in America each year, namely 10,5 per 100.000. This rate is even higher in Japan, Sweden, Denmark, W. Germany and Hungary, approximately 20 per 100.000.

According to Crane[21], suicide in terminally ill patients is often accepted as justified by physicians; family members and hospital staff express guilt, embarrastment and surprize. Some studies on suicide cases at Great Britan and Seattle, WA. showed more than 50% of them showed painful, disabling diseases, peptic ulcer, cardio-vascular disease or malignancy.

In some cultures, as in Japan, suicide is acceptable, even praiseworthy. In other cultures it is a taboo. Untill 150 years ago the bodies of suicidal deaths were not permitted to be buried in Christian cemeteries. Suicide was a crime in the USA untill 50 years ago. Suicide, in fact any kind of killing, is a sin in monotheist religions (Judaism. Christianity and Islam) because a human body is a part of God, it is holy, it is a noble existence on earth; nobody has the right to kill himself. Islam stronly prohibits suicide. Our profit Muhammed said in one of the Hadiths (Müslim C. 1, S. 72) «Whoever kills himself with a piece of iron will go to hell with the iron sticking in his body and will be burned forever. Whoever kills himself with a poison will go to hell with the poison bottle in his hand and will be burned there forever. And whoever commits suici-

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de by throwing himself from a cliff will go to hell as he is falling down and will suffer in the flames of hell.»([23])

Immanuel Kant([52]), a strong defender of authonomy, says although the individual has rights to his body, «to use the power of free will for its own destruction is self contradictory.» David Hume ([47]), an 18.th century utilitarian, in his book «Suicide» combines the principle of autonomy with the principle of utility to justify cetain types of suicide. According to Hume «the more one's life is plagued by suffering, the more justifiable is suicide»; namely if a person's relief of suffering is greater than the loss of community, then the suicide is a right act.

If a person's death brings great benefit to society, suicide may be even a heroic and noble act. In Roman history, all the nation relied upon Cato in their resistance to Caesar. Cato knew that he could not escape from Caesar's hands, By committing suicide the Roman nation's resistance became stronger. Namely Cato's death helped the nation to resist to Caesar's dictatorship in creating an ideal. Maybe hunger strikes could be interpreted as a suicide, in which a person intends to kill himself through hunger to obtain a goal such as his nation's independence or other political gains (Gandy's hunger strikes). Or some people could burn themselves to death to protest some acts. A few years ago a Turkish-Armenian burned himself to death at Istanbul Taksim Meydanı to protest the Armenian killings of Turkish diplomates. This kind of suicide is done by Buddhist priests too. The goal of this form of suicide is to help society at the expence of his own life.

Another kind of **alturistic** type of suicide is the Japanese pilots' practice of Kamikaze suicides during WW-II and a soldier's exploding enemy's ammunition depot. In these cases suicide is for a cause which is considered higher than one's personal life. This kind of suicide is more like the spirit of war. The killing of enemy in war is considered acceptable to defend your land and nation.

We can find some heroic **mass suicides** in history. Human beings have always preferred death instead of being slaves of their enemy. In 401 B.C. in their long Journey Ten Thousands (Xenophone was among them) sieged a fortress near Erzurum. The Taok people (a small city nation) committed suicide by throwing themselves down from rocks. ,After Alexander the Great died in 322 B.C. his

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successor general Perdikkas siegad Isaura (a Pisidian town east of Beyşehir). Instead of being dishonorable slaves to Macadonians, first they burned their women and children and their treasures, then they fought fiercely with Macedonians. When Perdikkas withdrew temporarily, the remaining few hundred Isaurians burned themselves too. When Macedonians entered into the citadel, they could not find any living saul[24]. Almost the same kind of mass suicide was committed by the Jews of Massada in 73 A.D. when they believed there was no way to save their lives except by being slaves to Romans. In these examples people saved themselves from being humiliated, being degraded and being slaves. They preferred a noble death to a dishonest life.

There is a **forced suicide** too. In this type of suicide person has to kill himself by the force of another person. The best example of this was the death of Murad the forth's chief physician. When Murad IV. was on his way to Baghdad (second quarter of 17.th century) he learned that his physician was an opium addict which was a cause for capital punishment. Sultan Murad forced his physician to swallow a very high dose of opium. There was no way to save his life, his begging pardon was useles. When his assistant offered him an antidote, the physician refused treatment, saying «It is better to be dead than to be alive during this tyrant's reign.»

If we go futher, we could say that smoking cigarettes for a cardiac patient or a patient with cancer of the larynx or lung cancer, continuing to eat carbohydrates for an advanced diabetic or to continue drinking alcohol for a patient of cirrhosis is a kind of suicide too.

So, what is suicide? Because it is so diverse subject, it is rather difficult to define suicide. Maybe the best definition is : Suicide is a deliberate taking of one's life. Shall we accept death as suicide in the cases of terminal or hopeless cases, in which a patient refuses treatment? Or is it right or wrong actively to commit suicide in terminal cases? How about excessive fasting in so called «Çile Çıkarmak»? And most important all, who will decide whether certain forms of suicide are wrong or right? Or what kind of suicide is praiseworthy or blameworthy?

Everyone's opinion is different as to whether a type of suicide is right or wrong. While one person says, for instance, for a protest

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suicide «Good for him, he died for his ideals, for his country», another may say «How stupid he was; there could be other ways to save his country» etc.

The physician is a human being too. No matter how we are trained or what religious or political beliefs we have, we cannot help judging whether a certain suicide is right or wrong. In this situation physicians are like other people. But we have a duty. A duty to preserve, prolong and spare a human life. Physicians have sworn oath since Hippocrates : «I will give no deadly medicine to anyone if asked, nor suggest any such counsel». In another words, the physician should not act as a judge or ethicist in cases of suicide, he should act as a physician by sparing and prolonging human life.

The physician should respect a patient's rights and freedom but are we really dealing with a rational, sound minded and so called «autonomous person?» In my ten years of practice in pathology and forensic medicine, most of the suicide cases (on autopsies) were either under the influence of alcohol or narcotics. I remember I could not drink rakı for about one year after my first suicide autopsy in which the body smelled of strong anise and alcohol. Man's judgement is impaired under the influence of alcohol and narcotics. In my 25 years of practice in psychiatry 3 out of 4 successful active suicides were either obvious psychotics or severe psychoneurotics. I strongly believe the rest of 1/4 were either undiagnosed mentally ill persons or they suffered from temporary insanity.

Some people really do not intend to kill themselves; all they want is to get attention; they play suicide as blackmail. Some of them are depressed and they are «crying for help», thus they need therapeutic help. Although they do not want to die, either they take higher doses of poison or accidentally they slipp of the roof or they are drowned.

When someone sees that a person is attempting suicide, his or her first reaction is to try to save him. It is not unusual to see that the rescuer may himself die while he is rescuing the suicide victim. This help is natural and for humanity. When people are not concerned about suicidal act, it means that the moral values of society are decreasing. This lack of concern is unfortunately true in other areas also in the society. People are not concerned that somebody

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else going to die, somebody is going to be cheated or insulted. Do not be surprised if the police is a spectator.

Time is also changing our attitudes and laws. A physician may be sued by a suicidal person for his being saved, saying «I am free to kill myself, it is none of your business, who gaye you the consent to save me?» Our answer to him and to the court should be «My duty is to spare and prolong human life. I used my right of statutory authority to treat.»

Another problem occurs when a patient needs to be secluded (locked up) to prevent suicide. A seclusion room in the hospital has all precautions. There is almost no way a person could kill himself. If a patient is committed by the court, a physician could lock the patient up in a seclusion room. If the patient is voluntarily committed, you cannot seclude the patient, but if you did not seclude him and he committed suicide in the hospital, the patient's family could sue you in court. Unfortunately several psyhiatrists have lost malpractice suits in this kind of suicide.

Let us repeat again, a physician's duty is to save the suicide case no matter what is the philosophy behind it, no matter how much a patient's autonomy is respected.

A physician usually sees suicide cases on an emergency basis. Very rarely does the doctor treat his own suicide case. When a patient comes to an emergency room or you are called to a suicide place on an emergency basis, you cannot know his motivation, namely whether it is genuine or fake, cry for help, either it is accidental or crime. For this reason it is physician's ethical duty to treat and save the life of suicide case.

Ethical obligation of the phycisian is to recognize his patient's tendencies for suicide. It is believed by most psychotherapists that a patient who talks about suicide will not commit suicide. But the opposite of it may be true too, namely a patient who talks about suicide will attemt suicide. As a precautionary measure, it will be better to consider every depressed patient as a potential suicide risk.

As it was mentioned earlier, suicide is not a crime in many countries, it is a crime to help the suicide. Turkish criminal law punishes the person who helps the suicide.

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EUTHANASIA

Euthanasia, literally means «Good Death» or «Gentle and easy death, a death with a little or no suffering.» More recently, the term euthanasia has been used for «Mercy killing», namely deliberately killing a patient who is suffering of extreme pain and agony and who has an incurable terminal illness. Euthanasia is the most fascinating and the most discussed issue in medical ethics and philosophy.

History :

In old civilizations, human rights were rather restricted for the benefit of the state and society; euthanasia, namely killing an incurably ill person, was permissible. As Plato says «Mentally and physically ill persons should be left to death; they do not have the right to live». The Spartans gave a good example to euthanasia. They killed the crippled and weak children and useless elderly people. The first century Roman writer Cicero said «What reason is there for us to suffer? The door is open to us -death, eternal refuge where one is sensible of nothing». Again in the old times incurable patients were drowned in the river Gange in India. Even in the 20. th century there are some Eskimo tribes that leave their hopelessly ill and old people to die in the wilderness.

First objection to euthanasia came from Hippocrates whose oath says: «I will not administer poison to anyone when asked to do so, nor suggest such a course». The Old Testament of Judaism prohibits killing; one of the Ten Commandments says «Thau shalt not kill.» Christianity brought more respect to human beings; accordingly, every individual has the right to live; only God creates human being and death is the wish of God. Christian thinkers in the middle ages emphasized the following idea: God gives pain to pay back individual's sins; the more a person suffers the more his sins

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are forgiven. For this reason it is not advisable to interfere with God's will.

Islam focused on the issue of death very clearly. There are several Ayets in the Koran about death. As with the Old and New Testaments, the Koran states that God is the only one who creates us and the only one who takes it away.

The first recomendation of euthanasia came in the 16.th century by Thomas Morus; he said «when there is no cure and a patient suffers too much; the patient should be convinced to die. The patient should realize that his illness is incurable, he is a burden to others and his suffering causes pity for the people around him.»(7)

The term «Euthanasia» was originated by Roger Bacon in the 17.th century. Bacon also gave details about its technique and recommended it should be executed by a physician.(7)

In 1889 the German philosopher Nietsche said that terminally ill patients are a burden to others and they should not have the right to live in this world. In 1920 the German thinker Binding recommended taking away «worthless lives» of hopeless cases. He argued that euthanasia is a doctor's right and obligation. In 1935 German Nazi Party accepted euthanasia for crippled children for «useless and unrehabilitative» patients. In the Nurnberg Trial it was learned that 275.000 people were killed in gas chambers. Anyone in a state institution could be sent to the gas chambers if it was considered that he could not be «rehabilitated» for useful work. The mentally retarded, psychotics, epileptics, old people with chronic brain syndromes, people with Parkinsonism, infantile paralysis, multiple sclerosis, brain tumors etc. were among those killed.

At the beginning of the 19.th century supporters of euthanasia became more active in the USA. The New York State Medical Association strongly recommended gentle and easy death. Even more active euthanasia proposals came to Ohio and Iowa state legislatures.

Valuntary euthanasia bills were defeated in Great Britain's parliament in 1936, 1969 and 1976. The USA Congress rejected active euthanasia, According to the Encyclopedia Britannica(28), active euthanasia is permissible only in Switzerland with many restric-

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tions. Dr. Emine Atabek(?) in her «Tıbbi Deontoloji Konuları» states that USSR criminal law, since 1922, has not punished for euthanasia if it is done by a person's wish for his relieve of misery, but I could not find the confirmation of Russian law in the available literature. In 1950 World Medical Association declared voluntary euthanasia is against the principles of international medical oath.

Recent Changes and Classification :

After new developments in medical technology during the last 20-30 years, euthanasia became more complicated and the most discussed subject in medical and general literature. Let us try to enumerate the reasons for these recent changes :

1 — After the Nurnberg trials, human rights became more popular, People became more aware of their rights about their lives as well as their rights about deaths.

2 — The nature of dying changed by the rapid advances in medical knowledge and technology.

a) Life expectancy has been extended; the cause of death has shifted from acute to chronic disorders. Terminal illnesses now last longer due to more sophisticated techniques in medicine. Physicians have become more able to extend life even if its quality is poor. Untill 4 decades ago pneumonia was considered «the friend of the dying», it was the number one cause of death especially among old people. But today it is easily treated with antibiotics.

b) Physicians became able to bring an individual back to life by cardio-pulmonary resuscitation (CPR) or «Reanimation», and in more extreme situations with heart lung machines.

At the present time the physician is able to prolong life for a cosiderable time, but he is also able to prolong death to the expense of extended pain and hopeless suffering. By artifical means, terminally ill and severely brain demaged patients may live in a comatose state for months or even years with no hopes of revovery for their major illness. This is called physiological life, namely the person is kept alive with artificial or extraordinary means while he stays unconscious.

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Let us try to give the most discussed and the most popular case of Karen Quinlan.

In April 1975 **Karen Quinlan,** 21 years old single girl, passed out after o few drinks in a party. She was put on a bad; a few hours later one of her friends found that she had stopped breathing. Her friends gave her mouth-to-mouth resuscitation and then took her to a hospital in a coma. The alcohol level in her blood was low; a small amount of aspirin and tranqulizers were found in her blood. These were not enough to explain the coma. Further tests showed that her brain had been extensively demaged. She was subsequently put on a respirator that pumped air to her lungs. She never recovered from unconsciousness; her weight dropped to about 32 Kg., her body was bent to a lenght of approximately 90 Cm. Doctors believed that she would never regain consciousness, and that she would be in a vegatative state. The doctors recommended stopping life support mesaures First her parents refused this procedure on religious graunds, but later accepted the recommendation after the encouragement of their priest. But this time her doctor refused to stop the machine because Karen was over 21 years old, not a minor and therefore her father could not give informed consent. The lower court refused to give guardianship to Mr. Quinlan because the judge thought he was not in sound mind due to his sorrow. Karen kept living in a vegetative life; during this time the news media was discussing pros and cons of this issue. In January 1976 the New Jersey Supreme Court decided that life saving measures could be discontinued, the doctor could stop the machine after the approval of the hospital ethics committee. Six weeks after the Supreme Court decision, the life support system was stopped but Karen started breathing on her own. Several chronic care hospitals refused to admit Karen; finally a hospital and a doctor agreed to take care of her. Karen lived in a vegetative state for almost 10 years and died in the summer of 1985 of pneumonia.

In the late 1960's a young resident physician in Ankara Medical School was electricuted while taking an X-Ray. He was reanimated successfully but he could not come out of unconsciousness. He lived several years in a vegetative state. Unfortunately I do not have enough documentation at this time on this case.

I am sure you wittnessed several times the following scene in a western movie : The Cowboy's horse is shot, the horse is in agony

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and tremors; the cowboy shots the horse to end its misery. This is an example of non-voluntary active euthanasia.

On November 26, 1985 newspaper Tercüman reported the following news : A young woman killed her mentally retarded and crippled child and then hanged herself. You can see this kind of news quite often in newspapers. In the same issue of Tercüman the well-known cardiac surgeon. Dr. Christian Barnard who did the first human heart transplantation stated that he favors active euthanasia and says he even helped his mother for easy and gentle death. This is an example of voluntary active euthanasia.

You may remember 2 movies shown on TRT during 1985. One was «Whose Life is it Anyway?» in which Richard Dreyfus played the role of a quadriplegic young sculptor who loses all functions except talking and thinking. He obtained a court order to discontinue medical care and a release from the hospital to die by himself. This is an example of voluntary passive euthanasia. In the second movie, «Amos», Kirk Douglas and Elizabeth Montgomery starred in a story of a nursing home nurse who killed old terminally ill patients with high IV doses of barbiturates.

Classification :

Euthanasia may be 1 - Active, or 2 - Passive.

Active euthanasia is «Killing» by a doctor or others. Passive euthanasia is «Letting die» by the doctor, others or by the patient himself.

Euthanasia also may be 1 - Voluntary, or 2 - Non-voluntary

Voluntary euthanasia is done with the patient's wish and consent. Non-voluntary euthanasia is done without the patient's wish and consent.

By combining these, there are 4 kinds of euthanasia :

1 — Active - Voluntary Euthanasia

2 — Active - Nonvoluntary Euthanasia

3 — Passive - Voluntary Euthanasia

4 — Passive - Nonvoluntary Euthanasia

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Active - Voluntary Euthanasia :

Ali bey has advanced lung cancer; both he and his doctor know there is no hope; Ali bey has severe pains and asks the doctor to give him a lethal medicine. Doctor gives him a high dose of IV morphine. Ali bey dies peacefully, painlessly and in a short time. Dr. Barnard's helping his mother's death also fits this kind of euthanasia.

Active - Nonvoluntary Euthanasia :

Bekir bey has an advanced pancreatic cancer with metastases. 2 weeks ago he died but he was resuscitated. Now he is alive but is in a severe coma since resuscitation. Bekir bey's family asks the doctor to give him a lethal drug. The doctor gives him a lethal medicine. Bekir bey dies. Amos may be an example of this kind of euthanasia. Another example could be an unmarried woman killing her illegitimate baby and burying it in the basement.

Passive - Voluntary Euthanasia :

Cemile hanım knows she has advanced metastatic cancer. She had surgery, then X-Ray treatment but the cancer continues to spread. She has lost her faith in medicine, basides she can no longer pay her medical bills. She refuses treatment, she allows herself to die. She dies at her home in two months after her decision.

Passive - Nonvoluntary Euthanasia :

Düriye hanım has a terminal cancer. She spent several months in the hospital; recently she developed heart failure and went into a coma. Her family has asked the doctor not to try any extraordinary means to extent her life. The doctor accepts this and Düriye hanım dies in 5 days. An unwed mother leaving her illegitimate baby on the street to die is another example to this kind of euthanasia.

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For voluntary euthanasia (either active or passive) the following criteria should be present :

1 — Patient has to give consent freely, without any outside influence.

2 — Patient has to have all criteria of competency.

3 — Patient has to write it as a «Living Will» which must be wittnessed and noterized.

4 — Diagnosis of condition should be correct.

5 — Doctor should give complete information on diagnosis, prognosis, other possible ways of treatment and actually how much the patient will suffer etc.

6 — The patient's mental condition may change from time to time; this is called «slippery slope»; before he signs a living will we should be sure about his mental condition.

7 — He should also be free to revoke his consent at any time.

Non - Voluntary euthanasia is done mostly for the following cases :

1 — Newborn crippled children (Down's syndrome, thalidomide babies, microcephaly, hydrocephalus etc.)

2 — Patients who are in coma or who are unconscious (as in Quinlan case).

3 — Mentally impaired as in the case of mentally retarded or organic brain syndrome.

Legal Aspects of Euthanasia :

Passive euthanasia became a popular subject after mid 1960's when advanced technology became more able to delay death (or extending life in dying patients). Physicians, churches, thinkers, humane and medical societies started defending passive euthanasia. Roman Catholicism, the most dogmatic religion, permitted passive euthanasia (1980), this was confirmed by the Vatican. During the same years the American Medical Association (AMA) also permitted

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passive euthanasia. The AMA statement says that the decision to cease «extraordinary treatment» is the decision of the patient and/or family. There is some ambiguity in Catholic permission. It recommends that the physician may give sedatives or analgesics to ease the pain and suffering of the patient and may increase the dosage of medication. In this situation a patient may die of toxic effects of medication; in this sense the procedure could be an active euthanasia. This sounds like «Hile-i Şer-iye» in Islam.

The idea of **«Living Will»** was developed in 1968. A competent patient signs a formal statement directing his physican, family, hospital and concerned parties to let him die in dignity of his incurable illness and not be kept alive with artificial, extraordinary and heroic measures. In 1977 California State passed the «Natural Death Act of California». This law protects the individual, doctor and hospital when there is a living will; the patient's family can also collects life insurance benefits. As of 1983 nine other states in the USA had passed natural death bills or **«riht-to-die»** legislation. The laws permit a competent adult to sign a directive (living will) that authorizes physicians to withold extraordinary, mechanical or artificial life support measures if the person is judged to be terminal and death is imminent. Each year, new legislation supporting living will passes in many of the states.

Active euthanasia is punishable in Turkish Criminal Law (article 448) as a deliberate murder. Passive euthanasia is also punishable as neglect in Turkey by same law (article 454).

Some New Terms in Euthanasia :

Several new terms came into medical terminology regarding euthanasia during the last 20 years. Let us try to explain them :

Death with Dignity : Means letting the patient die naturally, peacefully, sensitively, compassionately and ethically. It is the patient's preference to refuse further medical interventions. It should be respected for the autonomy of dying patient. It means that the doctor should avoid «heroic» or «unusual» and «extraordinary» interventions but still to continue to comfort the patient with pain medications, sedatives and decent nursing care with respect and compassion.

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Extraordinary= Unusual = Heroic measures : Methods, techniques, ways to be used to save a hopeless case. There is no good criteria of what may be considered ordinary or extraordinary. In a remote Anatolian village an appendectomy may be an extraordinary measure but it is ordinary in a city hospital. Also open heart surgery was extraordinary 30 years ago, now it is not. Generally very costly, very unusual, very painful, very difficult, very dangerous interventions are extraordinary.

Cardio - Pulmonary Resuscitation : It is also called mouth-to-mouth resuscitation. When the heart beat and respiration stop, the therapist gives air to a patient mouth to mouth and pressure is applied to the heart from outside at regular intervals. I am happy that new trafic laws require that every driver must know CPR.

Code or No - Code orders : Code order means to go ahead and do CPR or reanimation or other life saving measures. No-Code order means not to resuscitate or not to use extraordinary measures for a dying patient, namely leave the patient alone, let God take care of the person's fate. Patients entering in a hospital or a long term care facility (e.g. a nursing home) in the USA can sign a no-code request.

There is no written law when to resuscitate. The doctor and the patient have an unwritten contract; the patient consents for treatment, hospitalization, surgery etc. after he is informed by the physician. If a patient says **no** to any procedure the doctor has to go along with the patient. Suppose a patient's respiration and heart stopped. Are you going to resuscitate the patient? The patient is dead, he cannt say **yes** or **no**. How about next of kin (spouse, parent or child) or any other relative? Can they decide on cade or no-code? We know that our responsibility or unwritten contract is with the patient, not with the relatives.

If a patient left a living will, are you not going to resuscitate the patient? Or do you have right to refuse patient's will and not to reanimate him? Legally you have the right to refuse and resuscitate a patient if you believe he has a good chance to live longer. Mostly a competent patient and family say : «Doctor we trust you. Do whatever is good for your patient.» Here again you are left alone with your conscience. In fact, it is not the patient and family but the doctor who has all the medical knowlege. Namely, a doctor

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knows what he can expect after CPR; either the patient will have a good or bad quality of life after CPR in a certain degree. Many times even the doctor himself can not be sure about the outcome because the major deadly disease, cancer or heart disease will continue to be a threat after successful resuscitation.

The right policy for a doctor is to explain to the patient and relatives what is CPR, what we can expect, what are our chances to bring the patient back to life? What can we expect, as far as quality of life is concerned? What are the potential irreperable and irreversible demage?

Each family member's feelings toward the patient, each person's philosophy, and their feelings about inheritance may be different. In most cases nobody wants to take responsibility, nobody wants to feel guilty about the result. They leave the decision to the doctor. If things go bad they find a whipping boy; here the whipping boy is the doctor. The patient's relatives may say: «Father would be alive if the doctor had done CPR» or «The doctor already knew his chances were poor, he tortured our father.» Worst of all, your rival colleagues could be the source of some of this gossip, the Hippocratic Oath notwithstanding.

If a doctor does not want to write a no-code order and if he does not agree with the living will, he should explain all the facts and possibilities to the patient or family. If they insist on no-code:

1) The doctor may transfer the patient's care to another sympathetic colleague or,

2) The doctor may excuse himself from the patient's care on the grounds of «Conscientious Objection» namely, he says that this act is against his religious and moral beliefs. In this case not too many people can blame the doctor.

In some cases the phisician is not sure about the good results that no matter what the patient or relatives say, he should go ahead and do CPR. Suppose a young man was electricuted; in this case it is natural to do CPR, no matter whether relatives want it or not. This is a duty of the physician.

When a doctor agrees to do no-code order: He discusses the case again with the patient or with relatives in the case of a patient's

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unconciousness, then asks the Euthanasia Committee or Ad Hoc Committee of the hospital; when the committee agrees, he has a meeting with the individuals who are responsible in this partient's care to make everybody sure, then he writes a **no-code** order in a visiable place on the patient's chart. By doing this, unnecessary heroic measures should be avoided Do not forget the fact that heroic measures are painful to the patient, to the family and hospital personnel too.

Physician's Attitudes Toward Euthanasia :

Sudnow([79]) studied the attitudes of California physicians toward critically ill patients in emergency rooms. Patient's social worth or value played the greatest role for extra efforts to extend life. Younger patients were resuscitated more often than older ones. Fewer efforte were made for alcoholics, attempted suicides, drug addicts, prostitutes and criminals

This sounds like the triage system in war in which less wounded soldiers were saved at the expense of severely wounded ones in the battle field in order to treat them easily and in shorter time, and send them back to fight.

Crane's study([21]) showed salvageable patients were treated more actively than those with brain demage. According to Crane, 70-76% of doctors preferred brain death to cessation of heart beat as a criteria of death. «However, no more than 13% in any sample were willing to turn off the respirator without any consultation whatsoever.» Crane says : «The apparent contraindication between these two sets of findings can probably be explained by the fact that large doses of narcotics which both suppress pain and hasten death are not considered to be true examples of euthanasia by many physicians since the physician's intention is to suppress pain and not to cause death.»

Patients' Attitudes Toward Euthanasia :

Crane's study showed that patients prefer to die quickly, painlessly and with as little fuss or inconvenience as possible. People want to control their deaths. Also they prefer to die in their own

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homes. «The majority of each group favored euthanasia but they preferred not to be told whether or not they were going to die.»

Is the Cost of Prolonging Life Worth the Efforts?

When we decide to extend life, we have to consider the costs too. Take an old man with terminal cancer who afford maybe 3 months expenses of extraordinary means such as a respirator, intensive care, expensive nursing care, etc.; when he dies, how is his wife going to maintain her living financially? Or would money be more valuable to his widowed doughter and orphaned children? A close friend of mine needed an expensive teeth prosthesis. He jokingliy said : «Anyway I will die in a few years. Is it worth it to spend so much money?» Another anectode on this matter is the following story : A man from remote Anatolian village brought his wife to Istanbul for major surgery. Surgeon said it would cost 500.000 TL. to have this surgery. The villager said : «Are you crazy doctor? Instead of spending so much money to repair my wife I can buy another young and healthy wife in my village.»

In most western countries heath expenses are paid by health insurance companies or by the government. Insurance companies have become more cost conscious recently. For instance you cannot keep a patient for the treatment of anxiety more than 6 days, abdominal surgery not more than one week. If hospitals and doctors know they cannot collect the charges, should they resuscitate so many patients? In countries where health services are socialized. I believe hospitals do not want to keep patients too long. You cannot blame them; instead of spending a long time and cosiderable personnel and equipment for a terminally ill old man, they can treat more productive men.

Morality of Euthanasia :

Utilitarian theory seems to approve all forms of euthanasia. When suffering is too much and hope for recovery is not present, then the principle of utility necessitates putting the person to death. Because happiness is exceeding unhappinesss, it is better to bring the suffering to an end.

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Deontologists (Kant) emphasize autonomy. The patient has the right to use his autonomy as he wishes. Then the voluntary euthanasia should be accepted by deontologists. However the unconsciuos person is incompetent, he cannot express his choice, then the non-voluntary euthanasia is not compatible with this theory.

The following opinions came into the medical ethics literature during the last 10 years.

J Gay - Williams[34] oppose euthanasia and believes it is an intentional killing and against natural law because it violates the natural inclination to preserve life.

James Rachels[70] says both active and passive euthanasia result in the death of a person, therefore there should be no difference betweet them. If our goal is to bring suffring to a speedy end, then active euthanasia must be preferred to passive.

Tom L. Beauchamp[12], in his reply to Rachels, says that because passive euthanasia produces fewer negative consequences than active, passive euthanasia is more justifiable than active.

Philippa Foot[32] questions if we are ever justified in killing people for their own good. We cannot know the wishes of a comatose patient, therefore non-voluntary active euthanasia is wrong; however non-voluntary passive euthanasia may sometimes be acceptable because most people believe these patients would be better off dead.

Chief justice **Richard J. Huges**[46] justified his favorable ruling on the Quinlan case by writing that the «right of privacy permits a patient to decide to refuse medical treatment.»

The Catholic Church strongly opposes active euthanasia. But during the last 15 years it has gradually softened its stand against passive euthanasia. The Catholic church says: «It is not for euthanasia to give sedatives and analgesics to a dying person for alleviation of pain, when such a measure is judged necessary, even though they may deprive the patient of the use of his reasoning or may shorten his life.» In 1980 the Vatican declared that normal medical treatments should be used but life prolonging technology should not be applied for a dying patient because it increases suffering.

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Furhermore it is a burden to the patient, the family and the doctor, and it is expensive.

Protestant churches (1976) have also allowed passive euthanasia (voluntary and non-voluntary) because continuance of mere physical existance is neither morally defensible nor socially desirable nor it is God's will.

The Koran[58] has brought the issue of death clearly. Here are the Surahs of the Koran related to death: «Wheresoever ye may be, death will overtake you, even though ye were in lofty towers» (Nisa 4/78). «We appointted immortality for no mortal before thee. What, if you died, can they be immortal? Every soul must taste of death, and We try you with evil and with good, for ordeal. And unto us you will be returned» (Enbiya 21/34-35). «Say. Lo; the death from which ye shrink will surely meet you, and afterward ye will be returned unto the Knower of the invisible and the visible, and He will tell you what ye used to do.» (Cum-a 62/8). «Who hath created life and death that He may try you, which of you is best in conduct; and He is the Mighty, the Forgiving» (Mülk 67/2).

As a summary only Allah gives life and he is the only one who takes it away. Certainly you will not neglect your body to chance, you will take care of it as long as you are able, but only God knows when you will die. According to Islam, the soul is eternal. One's physical body dies but one's soul never dies. A true believer knows that his soul will go to Allah and its presence will continue in heaven.

What will be Physician's Position in Euthanasia :

It is important to distinguish between : a) Being sympathetic to euthanasia and, b) Executing euthanasia. A physician may feel pity toward a patient's suffering and agony, and he knows that there is no cure; his ability does not go further than to decrease a patient's pain. The physician's main duty is to prolong and preserve life but he is obliged to ease pain and suffering too. I hope active (voluntary or non-voluntary) euthanasia will never be permitted in Turkey. No matter how pity we feel for a suffering patient, euthanasia is like a crime. Medicine is a heavenly occupation; physician's duty is to preserve, prolong and spare human life. No matter how good his

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intentions, a physician cannot be a murderer. Only God gives and takes away life. A physician has no right to kill anybody. As you know, the hangman is picked up from the lowest level of society; nobody has any right to put into the role of a hangman. The physician has no rights to play God. The physician is not an executioner either. If you have a pressure from the patient, family or court you could defend your own autonomy and your moral standing («Conscientious Objection»).

Active - Voluntary euthanasia is already out of the question; it is a taboo. If a «Living Will» act passes in Turkey, namely if a patient puts his wishes in legitimate writing, we may go along with the idea to leave the death to the hands of God if we really believe that death is imminent and there is no reasonable hope (Passive - Voluntary).

Suppose you succesfully resuscitate the patient who now is alive; his heart, lungs, kidneys are working but he is unconscious, he is not responsive intelligently. Again suppose the patient will never regain consiousness, and for the rest of his life he will live a vegetative life; his family has obtained a court order to stop life sustaining measures. In this case who is going to «pull the plug?» Namely who will stop the artificial life sustaining measures? Everybody thinks it will be done by the doctor, at least the order will be issued by the doctor. Does the doctor have to obey the court order? Here again the doctor should have the right to refuse to stop life saving measures; he should use the conscientious objection principle.

What can be done for Dying Patient?

During the last 2 decades psychiatrists have become more interested in helping patients who are terminally ill. There is no established method on how to help them. Every psychiatrist may apply his own method but possibly supportive psychotherapy is preferable. Depending on the patient's personality make-up, different approaches may be applied. Many times the patient and the therapist know that death is imminent. In this case giving further hope seems unrealistic; it is better to prepare the patient for death. Let him learn how to deal with death without fear, or at least with minimal

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fear. I found the best method was Victor Frankl's existential approach (Logotherapy).

It is almost a tradition all over the world that when the doctor leaves the patient, clergymen, in the case of Islam hocas, arrive and they give religious last rites to the patient. Generally they read passages from the Bible or from the Koran or from the Torah according the religion of dying person. It certainly helps the patient and family. But clergymen should have some training in psychology or psychoterapy, then they could talk to the dying patient more reasonably. They could calm, soothe, quiet and comfort patients more easily and in this way patients might die more peacefully.

10 years or so ago some research centers tried LSD on dying patients. I remember there were some good results but at this time I do not have the available literature. After a dying patient received LSD, they dreamed of death, they reported that death was not as bad as they imagined; some even reported feeling that they were flying in heaven happily and peacefully.

Pain medication should be used freely in dying patients. We are very careful and stingy to give morphine or other narcotics to patients because of the fear of addiction. What difference does it make whether a dying patient gets addicted or not? More recently many states in the USA have passed legislation allowing physicians to prescribe marijuana to ease the pain of terminally ill cancer patients.

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CONGENITAL MALFORMATIONS

(BIRTH DEFECTS)

Congential malformations are defects present at birth. They could be single or multiple. Their cause may be genetic or non-genetic (teratologic). Teratologic agents are some drugs used during pregnancy, infections such as ruoella, cytomegalovirus, toxoplasmosis or irradiation during pregnancy. Here we will try to show some examples which usually lead to mental retardation and life-long crippling illnesses in order to be able to discuss the medico-ethical aspects of birth defects.

THALIDOMIDE BABIES: In 1961 a new sedative came into the market in Germany. It was marketed as «Softenon»; its generic name was Thalidomide. It was a good sedative and a mild hypnotic. The next year several babies were born with deformed extremities. Some of them did not have arms, legs or ears; their hands or legs were directly attached to the trunk. Some of them had only a head and a trunk. 3.000 Thalidomide babies were reported. Some babies became deaf soon. These babies looked like strange creatures. Some parents never wanted to see their children. According to Dr. van den Berg[14], some doctors yielded to the pleas of parents and gave softenon babies a fatal injection after birth. However, judges were not as sympathetic as doctors for this euthanasia. Judges condemned the parents and the doctors. Several malpractice suits were filled againt doctors, hospitals and especially against pharmaceutical companies.

In Thalidomide case, as in many other adverse drug reactions, doctors did not do the harm knowingly; they did not prepare the drug themselves. Since softenon incident, the inta-uterine effect of each new drug has been carefully evaluated in animals. Every drug has an adverse side effect. Drug companies in the USA publish

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every year a big volume entitled «Physician's Desk Reference PDR.» When you look at this book you hesitate to use any drug in it because it gives so much detail in every adverse effects, even some possible side effects of similar drugs. If a malpractice suit comes, the drug company may easily say: «We warned doctors about this kind of adverse effects.»

Some ingenious artificial limbs have been fitted to these babies. Nevertheless, many of them are still living as a burden to their families and to society.

DOWN'S SYNDROME (MONGOLISM): I am sure you have seen some children in your neighbourhood, even among your relatives, who have a rather peculier appearence. They have a broad head, an upward slant of their eyelids, a small and flat nose, a big red tongue, and may appear blank-faced and mentally retarded. Because of the above features, they are called Mongoloid. Almost all of them are mentally retarded, varying from slight to severe. Down's syndrome is a result of a chromosomal abnormalty; there is an extra chromosome 21 and genetically they are born to older mothers. The incidence is about one in 700 live births. They are a burden to their families who spend some of their income to take care of them; their social life is ruined; even baby sitters are reluctant to take care of them In addition to their mental retardation, their behavior is bad too. They are sometimes incontinent in their urine and bowel movements They may be so ugly that you have mixed feelings when you look at them. We pity for them but sometimes the pity may go to an almost rebellion to God; you try to avoid seeing them. The monkey in an animal and has a sympathy from us because of their intelligence and clawnish acts. But what charm do these Monogoloid creatures have? It becomes even more problematic for families and for society as these children become adults.

Unfortunately, in some ways fortunately, many Down's syndrome babies have other birth defects such as duodenal or esophageal atresia, unopened anus etc. They die of starvation if surgery is not done. They may have an esophago-tracheal fistula and they die of aspiration pneumonia if they do not have surgery.

SPINA BIFIDA: Defective closure of vertebral column. The child is born with an opening of the spinal canal due to the failure

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of lumbar vertebrae to close. Membranes covering the spine are exposed outside as a bulging mass; it is open to infections. These children's lower extremities are generally weak or paralyzed. Presently surgery is able to close and correct it easily but many childreen will have paralyzed legs.

HYDROCEPHALUS : Excessive accumulation of cerebro-spinal fluide within the ventricles. The flow of CSF is blocked; fluid accumulates in the head; pressure, 1 - enlarges the skull, 2 - causes the atrophy of brain tissue. Since 1957 a permanent tube (Holter valve) has been inserted in the brains of these children to drain the CSF into the chest or abodminal cavities.

Before the use of Holter valve these children died in their early months or years. Even after surgery the child may remain mentally retarded and paralyzed. It is also difficult to maintain the Holter valve; it may need several more surgeries. Some hydrocephalic babies also have spina bifida.

ANENCEPHALY : The child is born without a brain; the skull may be open as in spina bifida. Anencephalic children mostly die. If they do not die they will have a vegetative life. Fortunately this is a very rare condition

MICROCEPHALY : is a condition in which the brain, usually the cerebral hemispheres, remains small. These children cannot live long.

ESOPHAGEAL AND DUODENAL ATRESIAS : Some children are born with a closed esophagus or duodenum. The problem can be corrected by surgery, otherwise they invariably die. These defects may accompany Down's synrdome or other malformations.

ETHICAL ASPECTS OF CONGENITAL MALFORMATIONS

The whole problem centers around recent advances in medical technology. Before advances in pediatric surgery, children with duodenal or esophageal atresia, esophagotracheal fistula, closed anus, spina bifida, hydrocephalus etc. died soon after they were born due to malnutrition or infections. Modern medicine has made us able to extend the life of these children. Is it fortunate or unfortunate? Even if we correct the defect most of these children and

those with other malformations will be sick for the rest of their lives; they will never live a normal life (except duodenal and esophageal atresia or closed anus or esophago-tracheal fistula alone), and they may be mentally retarded.

Can you imagine how difficult it will be to have a Mongoloid or hydrocephalic child or a Thalidomide baby? Furthermore imagine the difficulty of these people attempting to make their own way in the world as they grow older. What happens to them when their primary caregivers, their parents die?

The greatest difficulty in the ethics of birth defects is that these children are **undesirable but livable.** The other question is: Are they really persons? A baby cannot decide how the quality of life will be in the future? Can parents, doctor, clergymen and society decide for them? Some Thalidomide babies expressed, in later ages, how happy they were to be alive. What is the parents' responsibility? Maybe you can say women who married late should never have babies. Or women should not have infections or should not take medications during their pregnacies, or blood relatives should never marry.

Doctors did not know that Thalidomide or other drugs could cause malformations when they came into the market. Maybe we can blame the advance of medical technology. If medicine did not advance so much (surgery and antibiotics), many of these children would die soon after they were born Why did medicine interfere with God's business? Or why God gave us the sense of pity? Why should a doctor be in conflict all the time?

The Holter valve or surgical corrections of spina bifida may save an infant's life but there is no cure for the after effects of hydrocephalus or spina bifida; the child maybe still retarded, may have deformities of his legs and spine; the child maybe paralytic and may not have control of his bladder or bowel.

The John Hopkins Hospital Case (1973) is the most frequently mentioned ethical case. This child was born with Down's syndrome and duodenal atresia. The parents did not allow the doctor to correct the duodenal atresia by surgery; the baby died in misery. This is a passive non-voluntary euthanasia. Many said active euthanasia

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would be more ethical because medical personnel and parents should not have so many days of pity and mental anguish.

According to **Utilitarian Teory** the social and personal cost of saving the life of defective children is greater than social and personal benefits. Therefore these children should not be allowed to live, they should be killed painlessly to end their suffering.

Deontological Theories are not clear in this matter. If we put ourselves in these children's place, we would not want to have such a miserable life. The human being has autonomy to die as well as autonomy to live. Therefore these children might be allowed to die.

John A. Robertson[73] says : «No obligation to treat exists when the costs of maintaining life greatly overweight the benefits. So omission of care is justified .....to prevent the occurance of a greater evil.»

H.T. Engelhardt[29] says these children are not persons. After the doctor gives full information on future expectations, parents must decide either to go ahead with treatment or not. If there is no hope to expect a full human life but only suffering, or when the cost of extending the life is very great for parents, euthanasia (passive or active) should be allowed.»

R.S. Duff and A.G.M. Campbell[25] say medical advances increase the life of these children but dehumanize patients and worsen suffering. There is no reason for the indignities of pointless treatment or the cruelties of hopeless disease. Therefore Duff and Campbell support the families' decision to allow these defective children to die or to be put on death.

Van den Berg[14] seems sympathetic for passive non-voluntary euthanasia for Thalidomide or other birth defect babies. He says if these babies have pneumonia they should not be treated; they should be allowed to die and the doctor should not be asked to save them.

The British Medical Association (BMA) [15] gives the same rights to severely malformed children as normal ones; namely the necessary ordinary non-medical care should not be witheld from them. Doctor' parents', any helpful colleague's cooperation is recommended. Parents should be given full information on options and

likely outcome with or without surgery or other means for active intervention. The doctor in charge is responsible for the initiation or witholding of treatment in the best interest of the infant. If there is any doubt in the mind of doctor or the patients, a second opinion should be sought. In emergency situations, if consultation is not possible with parents or anyone else the doctor must exercise his clinical judgment.

The World Health Organization[78] is ambigious on the ethics of defected newborn's. WHO recommends also that the doctor should discuss all the possibilities of outcomes with parents. However in severe defects as microcephaly «the parents and the physician alike would in most cases probably agree to the nature take its course.»

I have not been able to find the policies and practices in uTrkey regarding defective children in the available literature. Neither I have found any guidance in the Koran, nor in Hadiths nor in Fetvas on this matter except that the Koran says «Do not kill your babies for the fear of starvation» (Isra 17/31)

Fortunately medical technology has also helped us in decisions regarding the birth of some genetically defective babies. The use of ultrasound and other prenatal tests allow detection of many deformities and allows parents to decide before birth whether or not the infant should live. Pregnancy may thus be terminated for sound medical reasons.

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ORGAN AND TISSUE TRANSPLANTATIONS

When an organ or tissue cannot be treated with conventional methods of treatment the diseased organ or tissue can be replaced by the same organ or tissue. Medical techniques have successfully replaced sick tissues with artificial or natural tissues.

CLASSIFICATION :

1 — AUTOGRAFT : Replacement of a diseased tissue by the same tissue in the same individual. Replacement of burned skin, bone or blood vessel in the same person has been done successfully for a long time. Closed or narrowed arteries are replaced with the leg veins as in by-pass surgery.

2 — ISOGRAFT : is a graft between identical twins.

3 — HOMOGRAFT (ALLOGRAFT) is a graft between genetically dissimilar members of the same species.

4 — HETEROGRAFT (XENOGRAFT) is the graft or transplantation between members of different species. Replacement of human organ or tissues with animal materials have been tried unsuccessly. At the beginning of this century Voronof transplanted monkey testicles to impotent men and this issue became a rich source of material for literature and jokes. Last year an infant's heart was replaced with a Babbon's heart unsuccessfully.

5 — Diseased arteries are replaced by artificial synthetic vessels successfully. This artificial transplantation has been done frequently in modern medicine. Also artificial heart transplants has been done with mixed success.

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Our discussion will focus mostly on homografts. At this time when we talk about organ and tissue transplantation we mean homograft, namely transplantation of one organ or tissue from one human to another. There are two kinds of homografts :

1 — Diseased organs are replaced with another living human body's organs.

2 — Diseased organs are replaced by the organs of a dead body.

There are no serious moral or legal problems with autograft, heterograft or using artificial (synthetic) materials; informed consent is enough for these kind of transplants. But real moral, ethical, legal and religious problems arise when a human body's organs are replaced by the organs of another living body or cadaver. Our discussion will be on these last 2 issues.

Studies of organ transplantation started in the early 1950 s. The first kindey transplantation in 1950 was unsuccessful. The main difficulty in organ transplantation was the rejection of foreign tissue by the recipient's immune systems. The first successful kidney transplantation was done in 1954 from an identical twin by Drs. Harrison and Murray of Boston. The first heart transplantation from one human to another human was done by Dr. Christian Barnard of South Africa in 1967. Still later, liver, pancreas, heart and liver together etc. transplantations have been done. Researchers, naturally have done experimental surgeries on animals before they applied the method to human beings. Although there are many disappointments in organ transplantation, it is being done in thousands of hospitals around the world at this time. Still the biggest problem is the rejection of a foreign organ by the recipient. Some immune problems have been solved parfiatly. In 1980 an anti-rejection drug, cyclosporine, started being used. In 1984 more than 200 heart transplants were done in the USA alone with a survival rate of 80% for one year.

Because of the unavailability of a suitable donor in some cases, the first artificial heart (Jarvik hearts) was placed by Dr. William De Vries in 1983 in the chest of a man in his 60's, Barney Clark, who lived 112 days with his artificial heart. The second artificial heart replacement was done again by Dr. De Vries in Nov. 1984 on William

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Schroeder. This patient and a third are still alive today (July 1986), but both have had strokes as a result of the heart transplant. Some of these artificial heart transplants wait untill a suitable human heart is available; then the artificial heart is replaced by a natural one.

Before the discussion of the moral aspects of transplantation we must define death, because in most cases organ and tissue transplantation is done with the organs and tissues of a dead person.

DEFINITION OF DEATH

For the known history of medicine a person is pronounced dead when his breathing and heart beat have stopped. In Islam and other religions, death is referred to as the «last breath».

Earl Signs of Classical (and Medical) Death are :

1 — Absence of heart beat and peripheral pulses
2 — Absence of respiration
3 — Absence of corneal reflexes
4 — Absence of response to external stimuli
5 — Dilated pupils
6 — Presence of a bluish color of the lips

Later Signs of Death are :

1 — Algor mortis (decrease in body tenperature)
2 — Rigor mortis (rigidity of the body)
3 — Livor mortis (purplish discoloration of skin)

After the heart stops beating, cortical cells of the brain die irreversibly in 4-6 minutes; liver, pancreas, kidneys in 30 minutes; heart in 30-60 minutes. The skin, hair, bone, cartilage etc live several days, even several weeks. It means that the above organs should be transplanted during these time limits, namely before they are dead. It is practically impossible to do this procedure unless the donor and recipient are present in the operating room with two sets of surgical teams. However, with specific perfusion and freezing procedures, kidneys may be preserved up to 24-72 hours. Because

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only living organs and tissues can be transplanted, we have to maintain cardio-pulmonary function in order to keep the organs alive untill the transplantation procedure. This is possible in brain death.

BRAIN DEATH

This term came into the medical literature during the last 10-15 years. It simply means that brain is dead while other parts of the body are alive. If cardio-pulmonary resuscitation is successfully done within 4-6 minutes after heart and lung functions have stopped, the person will come back to life; if CPR is done later than 4-6 minutes, cortical neurons die, they cannot regenerate as other body cells. The cortex of the brain is the place to receive all the imputs from 5 sense organs; it registers memory, knowledge, judgment, and all the cognitive systems : movements are done by it. However the brain stem can resist a little longer (possibly 10 min.) to the lack of oxygen. The brain stem is the center of respiration and circulation, as well as other parts of the autonomic nervous system. In brain death, the entire brain, including the brain stem is dead; however, the functions of other organs, namely the whole function of body except brain maybe re-started with CPR or a heart-lung machine.

If the brain stem stays intact and the rest of brain (especially the cortex) is dead, a person lives without a respirator as in the Karen Quinlan case and in the Ankara case. This is called «Persistent Vegetative State».

Clinical signs of brain death : Irreversable cessation of all functions of the brain, deepest possible coma, absence of all voluntary and non-voluntary movements, fixed pupils and apnea. In brain death the patient's respiration and heart beat stops as soon as the respirator is turned off. Otherwise the patient may live up to 4-6 weeks. The best proof is a flat EEG (Electroencephalogram) for at least 24 hours. In an autopsy, the destruction of the entire brain, including the brain stem, is observed.

British physicians have a practical way to determine the brain death without the utilization of an EEG. In order to diagnose brain death, in addition to the absence of spontenous respiration, the following brain stem reflexes must be absent :

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1 — Corneal reflexes : There is no blinking of eyelids when the cornea is touched.

2 — There is no contraction of pupils in response to bright light.

3 — Oculo-Vestibular Reflex : 20 ml. of very cold water is injected into the one ear slovly, if there is a movement in one or both eyes, there is no brain death. Absence of any eye movements following injection into each ear in turn proves the brain stem death. According to the British criteria there will be no respiration for 5 minutes after the respirator is discontinued.

Clinical Signs of Persistant Vegetative State : Cognitive, namely higher cortical functions are irreversibly stopped. The patient is **awake but unaware** of his surroundigs, cannot interact with the environment, his eyes are open and move, there are facial grimacings and yawning, there are involuntary movements, breathing and heart beat are present without a respirator. The patient may live several weeks or years in this condition if he or she is fed and taken care.

The best criterion for brain death is supposed to be a flat EEG. But some authors have reported that electrical activity of the brain may be restarted in a few cases 24 hours after death. Also we cannot depend on the EEG in cases of death from freezing and poisoning with sedatives. Maybe you have heard some horror stories in which a cadaver came back to life in his or her grave (unreliable story of the death of Sultan Mustafa III). For this reason they bury the cadaver overninght in many communities.

Summary : Signs of brain death and presistant vegetative state

Signs of Brain Death

1 — Irreversible cessation of all brain functions
2 — Deepest possible coma
3 — Absence of all voluntary and non-voluntary movements
4 — Fixed pupils
5 — Apnea

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Proof of Brain Death

1 — Flat EEG (Electroencephalogram) for 24 hours and/or
2 — Absence of corneal reflexes
3 — No contraction of pupils in response to bright light
4 — Absence of Oculo-Vestibular reflex
5 — No respiration for 5 minutes after respirator is discontinued

Signs of Persistant Vegetative State

1 — Cognitive (Higher cortical Brain) functions are irreversibly stopped
2 — **Patient is awake but unaware of his surroundings**
3 — Patient cannot interact with the enviroment
4 — Eyes are open and move
5 — There are facial grimacings and yawnings
6 — There are involuntary movement (But not voluntary)
7 — Breathing and heart beat are present without a respirator.

RELIGIOUS AND PHILOSOPHICAL ASPECTS OR DEATH AND TRANSPLANTATION :

Western literature is full of articles on religious and philosophical aspects of death and transplantation. This matter has been debated in daily newspapers and in the minds of people for the last 2 decades. Philosophical and religious problems of transplantation come from 3 sources : 1 — The question of «What is death?», «When is a person accepted as dead?» 2 — Respect toward a dead person. 3 — Is it religiously acceptable to carry somebody else's organ or tissue? The same discussions were done for blood transfusion in the past too.

Many philosophers such as Michael Lockwood believe «a brain dead patient is, after all, dead» even if his or her heart beat and respiration continues. After all, a brain dead patient is not «a person» or «a human being», it is «a thing», it is a «corpe». For this reason life saving techniques, such as a heart - lung machine or CPR should not be tried unnecessarily.

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We still do not know exactly what is the soul or if there s even such a thing. If it exists, where is it located? How does it leave the body? Descartes located the soul in the Pineal Body. Religious thinkers and philosophers have mentioned it often but still it cannot be described well. In Turkish, death is expressed as «Ruhunu Allah'a teslim etti», «Ruhu uçup gitti», «Allah canını aldı». A loved one is called «Canım», «Ruhum», «Hayatım». People use the words can, ruh, hayat with equal meaning. When a person dies, all these 3 values (actually the same) go away irreversibly. God gave us soul while in the mother's womb and took it away in our death. The soul lives forever but the body decays and is lost, melted away into the earth. As religion says, we come from the earth and go back into the earth. The eternal soul goes either to the hell or the heaven, or goes into another body in a later date (Reincarnation).

After the soul left our body (taken away by God) right after heart and lung functions have stopped, the person should be accepted dead. But as we mentioned before, present medical techincs are able to restart the functions of organs after death and able to preserve them for a few days or weeks. Should we think we have brought the soul back into the body? The answer is «Yes» if we have done it in 4-6 minutes; it is «no» after that time. In fact skin, cartilage, bone, hair etc. live several weeks after a person dies. Have we not buried or burned (in case of cremation) these tissues while they were alive?

After the brain death definition, some religious ceremonies and rituals for the dead have also changed in some religions such as Catholicism.

In Turkey, Diyanet İşleri Başkanlığı Din İşleri Yüksek Kurulu gave a fetva on 19-1-1968 stating that organ and tissue transplantation and blood transfusion are permissible (caizdir) to save another human being's life under the following conditions :

1 — The situation of necessity to save a patient's life should be determined by a physician.
2 — The physician must believe that the disease can be treated by this way.
3 — The donor should be dead at the time when tissues or organs are taken out for transplantation.

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4 — The donor should have left some indication of consent for transplantation while he or she was alive. If person did not leave a will, still his or her family may donate his or her organs.
5 — No fee is requested for organ donation.
6 — Receiver (beneficient) should also consent for transplantation.

LEGAL ASPECTS OF DEATH AND TRANSPLANTATION :

Determination of death is important for inheritance, life insurance, taxes, marital status and especially for organ transplantation. Death has been defined as «irriversible cessation of respiration and heart beat determined by a physician according to customary standards of medical practice» (American Bar Association's definition.)

Since 1970 many states of the USA startet to pass laws on determination of death. Some states accepted Carpon - Cass model, namely «brain death pronuoncements can be made only when heart and lung functions are artificially maintained». Some states accepted the definition of the American Bar Association but emphasized irreversible cessation of brain stem function.

In 1981, the President's Commission of the USA made the following definition : «An individual who has sustained either, 1) Irreversible cessation of circulatory and respiratory function or, 2) Irreversible cessation of all functions of entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards».

The declaration of Sydney (1968 amended at Venice 1983) of the World Medical Association define death more or less as the USA President's Commission but leaves the decision to each nation as far as the removal of organs for transplantation is concerned. It also says «Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation.»

In the USA a person must make a donation document, «Uniform Anatomical Gift», while he or she is alive and carry it with himself, otherwise his organs cannot be taken for transplantation. In Europe, contrary to USA, a dead body's organs may be taken for transplan-

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tation if a person did not make a will stating that his organs cannot be taken. However, more recently it has become more difficult to obtain such organs without preautharization by the dead person in some Europian countries such as Scandinavian countries.

The Turkish parliament passed a law on 29-May-1979 on organ and tissue transplntation (Organ ve Doku Alınması, Saklanması, Aşılanması ve Nakli Hakkında Kanun). This law defines the conditions of organ transplantation both from living and dead bodies.

Article 3 : To buy or sell organs and tissues for money or other means are prohibited.

Article 4 : Any kind of advertisement (except scientific, statistical or media news) is prohibited.

Article 5 : Donors must be over 18 years old and competent. The donor's consent is obligatory for organ and tissue donation.

Article 6 : People younger than 18 years old but competent may donate their organs if they do it freely with sound mind, and without any force, by written or verbal consent witnessed at least by 2 witnesses. This consent must be certified by a doctor. The donor should be given all Information on procedures.

Article 7 : The doctor who removes organs or tissues should do the following :

a) Should explain all the possible dangers (medical, psychologic, family and social results) to the donor.

b) The donor should be informed how his donation will help the receiver.

c) A mentally incompetent person's donation should be refused.

d) A married donor's decision should be informed to the spouse and this should be certified.

e) The sale or other benefits for organ or tissues should be refused except for humanitarian reasons.

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f) The names of a donor and receiver cannot be disclosed except in blood and marital relationship.

Article 11 : For organ and tissue transplantation, death is determined by four physicians : one cardiologist, one neurologist, one neurosurgeon and one anesthesiologist in accordance with customary standards of medical practice.

Article 14 : If a person had not left an official or written will while alive or had not revealed his will in the presence of 2 witnesses to donate his whole body, part of it or organs for the purposes of treatment, diagnosis or scientific goals, his or her spouse, adult children, parents, one of the brothers or sisters or in their absence any relative who is present during the death may consent to take any organ or tissue for transplantation. If there is no contrary will or statement, any tissue such as the cornea which does not cause any disfiguration in the cadaver may be taken without consent.

No organ or tissue can be taken from a cadaver if the person made a statement against it while he or she was alive.

If a person's life is ended as a result of an accident or other natural disasters and if none of the above relatives is present during the death, his or her healthy organs may be taken without will or consent after death is determined as described on article 11 In the emergency cases where another person's life depends on the death person's organs by transplantation. (Last paragrapf was added in 1983)

As we see, this law seems very liberal, encourages transplantation and leaves very little responsibility to the physician. The most important weakness is the fact that it does not decribe the death; the decision of death is left to doctors. Possibly certification of death by 4 physicians is too much of a burden. More than one doctor's opinion may be necessary in doubtful cases. I hope a new law defining ordinary death and brain death will be very helpful to physicians. One important point should be kept in mind : Doctors who determine death should not be involved in transplantation process. This is extremely important from an ethical point of view.

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MORAL ASPECTS OF TRANSPLANTATION :

As stated above both Turkish transplantation law and the ruling by Diyanet İşleri Başkanlığı make it very clear that there should not be any payment to donor. This may create problems. The donor will take a risk, will give a tissue or an organ. Besides the danger of surgery, the donor loses time, has physical and emotional pain. The doctor does not do any benefit to donor; even he may do maleficence to donor... As you remember these are both against medical ethics.

A relative may feel obliged to give an organ He or she cannot refuse to give his or her organ to the beloved relative; the donor may be in mental conflict. For these reasons, donors should be given detailed information, advice; all possible physical and emotional camplications must be reviewed and revealed to donor. Feelings of the spouse and the children of the donor should be taken into consideration. There should not be an ethical obligation on the part of the donor. There should not be any psychological or social pressures. Voluntariness or completely free will with full comprehension, full disclosure and real competence are obligatory.

Both law and religious ruling are very generous and permissive in Turkey. Organ transplantation from a dead body should not create serious moral problems.

If a mother offers her kidney to her child :

1 — She should be informed of its risks and benefits, possible complications and alternatives.
2 — Tissue types should match.
3 — The mother should be physically and mentally healthy.
4 — She should not be unduly influenced by family pressures; namely the donation should not be against her wishes.

These criteria should also apply to other family members from whom kidneys or other organs are transplanted.

If the mother (or other relative) freely volunteers to donate her single kidney or other single vital organ, she should be examined carefully by a psychiatrist and again should be fully informed. In rare cases in which the donor is definitely going to die from other illnesses and insists on donating his or her organ, the donation may

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be acceptable and ethical. But if this idea is contrary to the physician's own moral criteria, he may refuse to perform the transplantation because this is not a risk, it is a killing.

COST FACTOR IN TRANSPLANTATION :

Trransplantations are expensive all over the world. As an example, these cost figures were taken from Time Magazine Dec. 10, 1984 :

	Transplants performed in USA 1983	Average cost	1 year success rate
Heart	172	$ 100.000	80%
Kidney	6.116	$ 30.000	60-85%
Liver	163	$ 135.000	65%
Pancreas	218	$ 35.000	35-40%

Transplantation is a pionnering and challenging subject in the present scientific arena. Scientific research is expensive and scientists sometimes spend all their life on a single project. Astronomical amounts of money are invested in doubtful projects. By research, easier and cheaper ways may be found in the future. Colorado governor Richard Lamm said «We have a duty to die and get out of the way with all our machines and artificial hearts, so that our kids can build a reasonable life High tech medicine is really a Faustian bargain, where for a few extra days of life, we have to pay the price that could bankrupt the country.» This statement has raised a tremendous outcry of anger among many segments of the American scientific, medical and lay community. Nevertheless, it is a dramatic expression of fact. We must balance this realization with the fact that astronomical sums of money are spent for lesser and often deadly projects such as war machinery in the life time of our generation.

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ABORTION

Abortion is the termination of pregnancy. It could be spontaneous or induced. Induced abortion maybe criminal, accidental, traumatic or therapeutic.

Fertilization occurs in Fallopian tubes when an ovum is penetrated by a sperm. Fertilized ovum is called zygote which goes to a series of cell divisions, becomes blastocyte and in 2-3 days it reaches into the uterine cavity. In the end of second week it embeds In the urerine wall. Untill 8.th week it is called embrio, then fetus. Earliest intervention of pregnancy may be done by drugs (the morning-after pills) to prevent the embedding of the zygote. Up to 12 weeks therapeutic abortion is done either by vacuum aspiration or dilatation and curettage (D&C). After 15-16 weeks it is done either by injecting saline solution into the amniotic fluide or by a surgical procedure (hysterotomy).

FREQUENCY :

Because of the secrecy, the statistics on the number of abortions are not dependable. It is told that there were 1 000 000 induced abortions in USA and also in France in a year. In a joint meeting of Turkish Medical Association and Turkish Bar Association in 1980, it is said that 30.000 women out of 250.000 induced abortions died in one year in Turkey.

CAUSES OF INDUCED ABORTION :

According to a survey of current world legislation on abortion laws in 1970 by World Health Organisation, the induced abortion may be performed in one or more of the following situations :

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1) When mother's physical and mental health in in danger.

2) When there is a possibility of congenital defects in future child occurs, such as mother's having **infections** (such as rubella or some other illness), **drugs** (such as thalidomide etc.) or **radiation.**

3) When certain genetically transmitted illnesses (such as Down's syndrome, Tay-Sacks disease etc.) is diagnosed by amniocentesis or by other means.

4) When the pregnancy is the result of incest and rape, and when mother is below a specified age.

5) When the parents are mentally defective and considered to be incapable of caring adequately for a child.

6) When there is a serious socio-economic reason.

7) In the most liberal countries, when the child is unwanted for sex, number, lactation and even «Abortion on demand» or «Abortion on request».

RELIGIOUS AND MORAL ASPECTS OF ABORTION :

Human attitudes towards the induced abortion changed by time. During the Antic times, attitudes towards abortion was liberal. However, Hyppocrates viewed it as unethical. Christianity strictly prohibited induced abortion because fertilized ovum was accepted as a human being. However, some denominations of Christianity, later, allowed abortion very reluctantly if mother's life was in danger. Abortion is a sin in Islam unless it is done in order to save mother's life. Legal status of abortion also changes according to each nation's politics on the demand of the size of population.

Untill 10-15 years ago induced abortion was a crime in most of the countries. When women realized their rights, they put pressure on legislators that it should be their decisions to carry and deliver an unwanted child or not.

Philosophical, religious and legal debates regarding induced abortion mostly comes from the fact that we are not sure when a fetus is a human being. In the biological sense, life starts right after

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fertilization. Namely the fertilized ovum is alive. But biologically a sperm and an ovum are alive also. The biggest question is : «At what point in its development should the embrio or fetus be regarded as having acquired human rights?»

Human beig has the right for life only when it is alive according to religious and philosophical view namely, when the soul is together with body. When the soul leaves the body, then the human is called dead. Namely, as long as a human being does not have the soul, it is a corpse, it is a dead body. Aristotle said body and soul of the fetus do not unify during fertilization; they unify in 40 days in boys and 80 days in girls.

Koran does not answer clearly when the life exactly starts. But Hz. Muhammed[23] gives us an idea on the creation of a human being : «The origin of yours starts with the accumulation of **nutfe** in uterus in 40 days, then this becomes an **aleka**, a hanging mass, In another 40 days it develops to **Mugda** (a chewed meat). After 40 more days (120.th day) God sends an Angel who writes its destiny. its acts, its sustenance, its being either believer or non-believer and blews God's spirit into the fetus (then the fetus has a life)», (Buhari, et-tevhit, B. 28)[71]

Islam has prohibited to abort the developed fetus especially after its organs has well developed. However, Islam also believes that mother's life cannot be sacrificed for the sake of the baby, Gazali [23-35] (İhya II. 64-65) belives the degree of criminality of abortion is proportionate with the developmental degree of the fetus. Abortion after the unification of soul and body (120 days) is a bigger crime according to Gazali.

A scientific group of World Health Organization made the following recommendation in 1974[78] : «A fetus born before 22 weeks of gestation and weighing less than 500 gr. had no possibility of survival today and little more likelihood of survival in the near future». This group recommended that expulsion from the uterus of the fetus of 500 gr. or more should be reported as a brith, although it recognized that with periods of gestattion of 22-28 weeks, corresponding to birth weigh of 500-599 gr. the chances of survival were slender.»

According to Deontological Theories (Kant, Ross, Rawls), woman has the right to control her own life; she has the personal

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freedom and autonomy; it is her right to terminate the unwanted pregnancy. But deontological theory has difficulties when we think form the point of fetus who also has the right to life. Deontologists are not clear in this respect.

Utilitarian theory seems more liberal in induced abortion If abortion brings more happiness than mother's physical, mental and social unhappiness, why there should be an objection to the abortion.

In contemporary writings, conservatives (such as John T. Noonan)([64b]) believe the life starts with conception and abortion is unethical at any stage; liberals (such as Michael Tooley) ([87]) believe the life starts after the birth, namely it becomes a person and say that abortion is not a murder, woman has the right to decide on her body. Moderate thinkers are liberal in certain abortions such as pregnancies as a result of rape, incest, mental illness, mental deficiency, mother's serious illness, unmarried teenagers, some drugs and infections which cause malformations. In these cases abortion is a «self defence» and should not be accepted as a murder. But induced abortions for socio-economic reasons and population control are not ethical according to this moderate group.

LEGAL ASPECTS OF INDUCED ABORTION :

Untill 10-20 years ago laws were rather strict in induced abortion in almost every country. But at this time the majority of nations are more liberal in abortion.

According to Turkish Criminal Law abortion was a crime, both mother and physician had heavy prison sentences in the case of abortion. The USA Supreme Court ruled in 1973 that abortion laws in the states were unconstitutional because they were restricting the right of privacy; unborn child was not a «person» for purposes of constitutional protection of its rights.

The Number 2827 law on population control in Turkey is rather liberal and realistic. Article of said law says that for the sake of mother's health, abortion is permissiple up to 10.th week. After

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10.th week abortion is still permissible if mother's life is in danger or would be in danger or if the baby will carry serious crippling diseases to offsprings; in these situations a report based on objective findings, by an obstetrician and a related physician is necessary. Article 6 of said law defines who will give the permission for the abortion : Pregnant woman may give the permission in most of the cases; pregnant woman and guardian for minors; in the case of the incompetent pregnant woman, court gives the permission upon the guardian's and mother's application. Mentally incompetent mother cannot give a permission.

Above mentioned law gave a big relief to physicians and woman in Turkey. When a mother wants to terminate her pregnancy up to 10.th week, the physician may give any medication for abortion. If a D&C or suction is necessary for abortion, the physician could do it by himself or may refer it to another physician. In every case of induced abortion, the physician must obtain an informed consent. If the physician does not want to perform an abortion for personal reasons, he or she may refuse it on the grounds of conscientious objection, because the legality of abortion does not mean it is ethical.

WORLD MEDICAL ASSOCIATION'S POSITION IN THERAPEUTIC ABORTION :

WMA drew up a statement in 1970 on therapeutic abortion. This code (The Declaration of Oslo) was amended in 1983 in Venice. Final code is as follows : (See Appendix X)

1 — The first moral principle imposed upon the physician is respect for human life from its beginning.

2 — Circumstances which bring the vital interests of a mother into conflict with the interests of her unborn child create a dilemma and raise the question whether or not the pregnancy should be deliberately terminated.

3 — Diversity of response to this situation result from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected.

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4 — It is not the role of medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the physician within society.

5 — Therefore, where the law allows therapeutic abortion to be performed, the procedure should be performed by a physician competent to do so in premises approved by the appropriate authority.

6 — If the physician considers that his convictions do not allow him to advice or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague.

7 — This statement, while it is endorsed by the general assembly of the World Medical Association, is not ta be regarded as binding on any individual member assiciation unless it is adopted by that member association.

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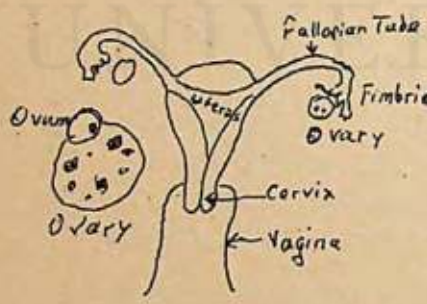
REPRODUCTIVE CONTROL

Combination of science and freedom of mind can do many things that were not imaginable even a few hundred years ago. Many dynasties in history disappeared or many happy marriages were ended because of inability of reproduction. Handley-Jackson's[36] research showed that there were no children in there-fifths of divorces out of 421.000 divorce cases in the USA. On the other hand, many poor families shared their limited bread with many unwanted childreen. Men and women were terribly afraid to have a decent sex because the fear of pregnancy.

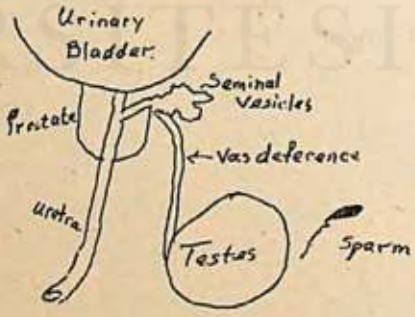
In this chapter we will discuss artificial insemination, in-vitro fertilization, sterilization and population control.

ARTIFICIAL INSEMINATION

Artificial insemination is done in order to give a child to an infertile couple. Infertility is the inability to produce a living child. Although the timing is arbitrary, generally it is said that a marriage is accepted infertile after one year regular sexual relations. Roughly about 10-12% of couples are infertile; 45% of them are male's, 50% of fermale's and 5% of both spouses' infertility.



Female Reproductive System



Male Reproductive System

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Here are the schematic drowings of female and male reproductive organs. Sperm comes from testicles to seminal vesicles through vas deferens and accumulates there; after mixing with a secretion in prostate, it comes out with ejaculation. Each month one or more ova develop in the ovaries; they drop into the abdominal cavity to be taken up by fimbriae to the Fallopion tubes. Ovulation occurs in female human being 14 days before next menstrual period. If a copulation happens at this time sperm goes into the Fallopian tubes and fertilizes the ovum there. But it is not so easy. Besides hormonal and chemical disorders, sometimes there are some physical problems prohibiting the union of the sperm and the ovum: Here are the main couses of sterility in each sex :

In Men : There could be congenital abnormalities in penis and uretra, semen goes into the bladder instead of going into the uretra, (such as diabetes and certain drug use) or semen does not go to cervix due to a congenital abnormality (hypospedias) or there is no erection (physical or psychological) even though the sperms are produced normally in the testicles; or there is no sperm at all (aspermia or azoospermia) or not enough sperms (oligospermia); or sperms are either immobile or dead. Testicles may be atrophic due to mumps or other infections or trauma or as a result of undecended testicles or plain hypogonadism. Vasectomy for voluntary sterilization is another cause of male sterility.

In Women : Either cervix or uterus or Fallopion tubes or a combination of them may not be present from the birth, or they may be faulty. 45% of infertile women has abnormal or obstracted Fallopion tubes. The cause of obstraction in Fallopian tubes maybe as a result of infections or surgeries including vuluntary tubal ligation.

At this time, medicine is able to correct some of the defects; but some defects cannot be corrected. In these cases there are ways to bring the sperms and ova together for fertilization with such techniques as artificial insemination, in-vitro fertilization or by using surrogate mother.

Depending on to different defects in male and female the following artificial insemination procedures are done :

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1 — ARTIFICIAL INSEMINATION WITH HUSBAND'S SPERM (A.I.H.) or HOMOGENOUS ARTIFICIAL INSEMINATION

This type of AI is done either by a) Fresh semen of husband or, b) Frozen semen of the husband. IN AIH wife is fertile (normal), but husband does not have enough sperms (oligospermia) or he cannot have erection, or he has some physical abnormalities on the path of semen. Husband's sperm is collected and injected into the cervix of wife with a special syringe on the day or around her ovulation. The procedure may be repeated 3 times in one menstrual period.

b) AIH with frozen sperms of the husband : Husband's sperms are normal but either 1 — He is going to have X-Ray treatment of cancer or lymphomas or in the case of husband's voluntary sterization or, 2 — If a wife still wants to have a baby after her husband's death, sperms are frozen in glycerol in cryogenic laboratories and kept in sperm banks

A.I.H. was first done by John Hunter in 1790. At the present time probably 2.000 children are born per year by this technique in the USA (44)

2 — ARTIFICAL INSEMINATION WITH A DONOR'S SPERM (A.I.D.) or HETEROLOGOUS A. INSEMINATION :

Wife is fertile. Husband is infertile due to lack of sperm (aspermia or azoospermia) because of congenital or acquired abnormalities of the paths of sperm, atrophy of testicles etc. In this technique sperm is obtained from another male either freshly or through sperm banks. Same procedures as in No. 1 is done for insemination.

This type of artificial insemination is very popular in animal breeding. It is said that Arabs have done it since 14.th century.

There are 3 most frequent indications for A.I.D. : 1) Absolute male sterility,, 2) Hereditary disease in the husband, making propagation inadvisable, 3) Rh incompatibility when an abnormal baby whould be anticipated. (Finegold).

Emotional stability and intelligence of the couple should be carefully evaluated. Generally intellectual couples ask for A.I.D.

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Donor should be free of any transmittable diseases, his intelligence and physical appearance are preferable to be close to father's Donor's blood should be compatible with the woman. Donor's being anonimous is very preferable. New York City sanitary code (1950) says donor will be free from gonorrhea, syphilis, tuberculosis or genetical defect and recipient (mother) will be Rh. compatible with donor. In order to decrease the doubts, some practitioners mix the semen of donor with father's semen.

Ovulation time maybe determined by vaginal temperature and with some signs in woman.

3 — IN-VITRO FERTILIZATION OR TEST-TUBE BABY :

In-vitro means «in-glas». In-vitro fertiliziation is in fact an embrio transfer. It is done in the case of mother's being infertile due to the absence or occlusion of Fallopian tubes which is 45% cause of female infertility Father is fertile and normal. However theoritically in-vitro fertilization may be done with a donor's sperm too (although I am not aware of this situation happened).

One or more ova are taken with a thin vacuum aspirator around the time of ovulation; at the same time husband's (or sometimes donor's) semen is obtained and they are incubated in a certain technique. Fertilization is observed under the microscope; then fertilized ovum goes into cell divisions. If more than one ovum is fertilized, the unused ones are discarded. Scientists became able to observe the first days of human development under the microscope. When division comes to about 8-16 cells-stage of division (2-3 days) the embrio is placed into the mother's womb with a special syringe. Before the procedure, mother has to be prepared for impregnation with proper hormones.

Landrum B. Shettles was the first known scientist who was able to fertilize a human ovum with a human sperm in 1954 and kept it alive 6 days in a test tube. But he quit his experiments because of strong objections from physicians and church.

First in-vitro fertilization was done by Drs. Patrick Steptoe and Robert Edwards in Nov. 1977 and baby girl Louise Brown was born on July 25, 1978 at Oldham General Hospital in England. Since then hundreds of tube babies are reported all around the world.

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In-vitro fertilization opened new horizons to science: The science is working to find new ways of better contraception methods by experimenting different agents on developing embrio. Possibly the science will be able to control the genetic defects with this techique.

4 — SURROGATE MOTHER:

A genetically superior cow's ovum and bull's sperm are fertilized in-vitro, then several embrios are transferred into the uterus of ordinary cows. I could not find in available literature that this technic is applied in human beings*. But this is a possibility in the cases in which, a) A woman has no uterus (hysterectomy or fibroma of uterus), father is fertile The mother's ovum is fertilized with the father's sperm and then implanted into the uterus of a hired (surrogate) mother. b) Mother is completely sterile (no ovaries, no uterus), father is normal. Another woman's ovum is fertilized with father's sperm and implanted to surrogate mother. Or 3) Both husband and wife are completely sterile; ovum and sperm are obtained from different women and men, after fertilization in-vitro they are implanted into the surrogate mother. This last one is a fiction but it is possible.

ETHICAL ASPECTS OF ARTIFICAL INSEMINATION AND IN-VITRO FERTILIZATION:

The science in reproductive control has advanced faster than the society's values. Society could not catch the speed of science. While society and legislators were discussing A.I H., and then A.I.D. science brought out in-vitro fertilization. You cannot change the strong beliefs which developed in thousand of years in human societies in a few decades. The science is disregarding the nature and religion in reproductive control. 10 years ago a few states in the USA legalized artificial insemination. Till then all the artificial inseminations were done somewhat secretely.

(*) Yesterday TRT gave the following news: In the USA a couple hired a surrogate mother for $ 10.000 In-vitro fertilization was done. After the baby was born, Surrogate mother did not want to give her baby to the couple. Court rulet against the surrogate mother.

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It is very difficult to do a decent research on the ethics of artificial insemination because of the secrecy in this field. Informants are hesitant to give answers due to the fear of law, religion and society. Another difficulty comes from the fact that the science is not sure actually there would be any abnormalities in the future child because the artificial insemination procedure is new. Namely, what would be unknown risks to the potential child? Research needs thousands of artificial insemination babies in order to come to a reliable conclusion.

Human being cannot help to imagine to have «human hatcheries» in the future. In this case the sexual act whould be only a recreation; woman's job would not be to repreduce a baby. Babies would be produced in factories as people want with predetermined characteristics, genetically superior human being (superman) as in the fiction stories.

When we apply ethical theories to the artificial insemination, **Utilitarian theory** should accept it because there is a greatest happiness for the greatest number of people. Artificial insemination should not be objected by **Kantians** neither as long as an informed consent is obtained because every human being is an autonomous being and the action satisfies the categorical imperative. For the theory of **Ross**, the prima facie duty is to be beneficial, therefore artificial insemination should be ethical.

Ethics of artificial insemination should be discussed from the aspects of, 1) Religion, 2) Legal, 3) Family, 4) Malpractice, 5) Society's values, 6) Future child's standing in society.

Christianity and Judaism object the act of masturbation. Sometimes the fertilized ovum is discarded during in-vitro fertilization; should it not be a kind of infanticide? Religion objects infanticide and abortion strongly. A third objection of religion is that the artifical insemination, per se, is against the nature. There is no clear statement in Koran and in Hadiths on artificial insemination but Islam should be definitely agaist it. In 1970 a responsible person from Diyanet İşleri Başkanlığı openly condemned artificial insemination.(7)

Except religious objections, there should not be any legal objection in A.I.H. However, there is a possibility that husband may feel impotent, incompetent because of his deficiency, his not being a father in a normal way. Possibly the wife may look her husband

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down. If the child is raised in a proper way, there would not be any negative psychological effects in the child.

If A.I.H. is done after father's death, what kind of legal problems may be expected? Law accepts fatherhood up to 300 days after his death.

Problems in artificial insemination with donor's semen :

Religious problems : A.I.D. is counted as an adultery and religion accepts these children as bustards.

Legal and Psychological Problems : Should the mother has the rights for abortion in case changes her mind? What will happen to child in case of divorce? Could not the mother reveal the facts in case of custody? What are the provisions for donor? Can he claim legal and psychological rights on the child? Or can the child ask inheritance from the donor? Could father feel guilt, anger, rebellion? Could he deny inheritance to the child? How will father's love be towards the child? Inferiority feelings may develop in the father if the child is more intelligent and physically superior to him. If mother's curiousity leads her to find out biological father (donor), could she develop love towards the biological father of her child? Mother may develop a strong feeling towards the donor whenever she looks at her baby.

What will be the position of the physician who helped artificial insemination? What are the possible risks? What are the possible malpractice suits if parents are dissappointed with the results? Could not the doctor be a whipping boy? How we can protect the parents from curiousity of public and news media? It is said that Dr. Steptoe hired a detective to protect Brown family. Can a physician inseminate a woman with somebody else's sperm without the husband's consent?

How the child will feel towards his or her legal father and biological father if he finds out he is the product of an artificial insemination? How the child's friends and generally society will look at him? As a legitimate or illegitimate child?

What are the responsibilities of the sperm bank? How accurate are their imformation on donor? How much they can depend on computers? How strictly will sperm bank keep confidentiality? Could parents not bring suits against sperm banks? Is there possibility to mix the sperms? How about giving a black man's

sperms to a withe woman? Could the sperm bank reject the order of the court on the graunds of confidentiality?

Another problem comes in the respect of incest. How can we be shure donor's real children will not marry to one of his artificial children? At one side we ask strict confidentialty, on the other side we want to know who is the biological father in order to avoid the incest.

What about surrogate mother's legal rights, her feelings, her claims? What happens if she wants the baby whom she carried 9 months? Can surrogate mother abort the child if she wants? What are the legal rights of husband and wife on the case of abortion? How strictly surrogate mother follow dietary obligations? All the possibilities shoul be written in contract to avoid above outcomes(*.

How about donor's position? Could he claim legal rights? Is he going to be paid by sperm bank for his sperms? If not, why in the first hand he gave his sperm? What was his motivation?

Another big question is that should and can a physician go along with an unmarried woman's demand for artificial insemination with a donor's sperm?

In case if one of the spouses wants A.I.D. and other objects, what will be the moral and legal aspects?

Phisician who performs the procedure should consider the following points in artificial insemination :

1) Before performing artificial insemination, both husband and wife must be carefully examined to find out there is a sterility. Some defects should be treated first. If there is no hope of reasonable treatment, the following points should be evaluated :
2) Physician should carefully evaluate spouses' psychological and social status;
3) He should give a comprehensive information to parents to be sure they are fully aware of consequences. All 4 elements of informed consent (Disclosure, comprehension, voluntariness and competence of consent) should be exercised and consent should be a written contract.

(*) See the footnote at page 120

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4) The physician should be very careful in the selection of the donor to avoid possible genetic disorders and Rh. incompatibilities.

5) The physician should keep confidentiality regarding the identity of the donor. Namely, the donor should be anonymous; there would not be a client or dependent relationship between the physician and the donor

6) The physician should take into consideration of society's reactions and feelings of spouses, child and donor.

7) The physician should be careful to avoid commerciality of sperm banks; he should not allow sperm bank to advertise the semen of a genius or the most handsome man etc.

POPULATION CONTROL

In known history, population policy was prime concern of every nation. After wars, great famines and epidemics population of the nations decreased considerably. For instance, Europe lost 25% of its 105 million population after plague epidemic of 1348. In order to increase the manpower, governmets encouraged births.

In the past, peasant agriculture has depended upon manpower; infant and child mortality was high, reproductive period of couples was short due to short life span. When these combined with religious and traditional beliefs, population policy was in favor to encourage more and more births.

According to recent findings human being came into the earth 3 Million years ago. The population of world was able to reach to 1 billion. In 1830. The increase of population frightened the scientists In 1798 Thomas R. Malthus developed a theory (Malthusian Theory) that in every 25 years or so population doubles but food supply does not increase with same multiplication. Malthus recommended birth control, otherwise human beings should die of starvation.

After mid 19.th century, population of the world increased more dramatically due to our ability to control epidemics, finding new medications for diseases, better feeding and care etc. Before WW-II the population of the world was 2 billions. Now in 1986, it is 4 bil-

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lions. This a **Population Explosion.** The latest United Nations projection is over 6 billions in the year of 2000 and with this rate of increase the population of the world will be 150 billions in the year of 2200. Agricultural revolution is a temporary solution of the problem of feeding.

Statistics show that in Western Europe and Developed Countries population increase is almost static, poor and developing countries are showing higher rate of increase.

What are the reasons to control population?

1 — World needs less manpower because agriculture is mechanized, industry is going to automation.

2 — Present wars need high technology and qualified man power, not necessarily man power in terms of numbers.

3 — Reproductive period has extended due to longer life span.

4 — Child death rate decreased, epidemics are under control; famine is present but at least now prosperous countries may help to feed them. Transportation is easier to deliver the food in to the famine areas.

5 — Religions and traditions are becoming more reasonable as far as birth control is concerned.

Population policy is a really touchy problem. Underdeveloped countries say that Western Europe and USA are trying to dictate them on their population. Governments in some countries lost the elections for their insistence in population policy such as Indira Gandy in India. Some countries are sincere and see the danger, others still encourage population increase.

U.N. Population Conference in Bucharest in 1974 showed that rich countries and the most Asiatic countries were agree to reduce population, but Latin America and African countries preferred to fight poverty and underdevelopement instead of reducing the population. Teharan Proclamation of 1986 expressed the right of family as follows : «Parents have a basic human right to determine freely and responsibly the number and spacing of their children.» The World Health Organization decided to provide knowledge to nations on better birth control methods and left the right to each nation to formulate their own policy.

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Almost every religion encourages human fertility: none of the birth control methods, except Natural Family Planning, is permitted by Roman Catholics. During the last two decades many religions and denominations are becoming more linient in contraceptive methods. Moslem religion is more realistic in contraception. In one of the Hadiths (Buhari [17]. Nikâh 96) Hz. Muhammed recommended withdrowal method in order to prevent pregnancy. Gazali [35] (Ihya II. 65 - 67, Mısır 1967) and Ibnul-Kayyim al-Cevziyye thought that Azi (withodrowal), as other means, is definitely permissible when it is done with the mutual agreement of husband and wife in certain instances such as economic hardship, fear of not being able to rear the child properly, mother's illness or weakness. But it is not permissible when it is done for not to have a baby girl, for esthetic reasons and worries of not being able to nurse the baby.

Azl means withdrowal. Islam thinkers believe Azl is permissible, the other acceptable birth control methods should be permissible too. It should be with couple's own desire, not because of outside forces.

In Dec. 1960 Diyanet İşleri Başkanlığı gave a report to the government, stating that birth control was not against the Islamic prinicples.

The population policy changed in time in Turkey too. After WW-I and the Independence war the population of Turkey considerably decreased. Until 1960 Turkish governments encouraged families to have more children. But when the population increased more than government wanted, birth control has been encouraged in Turkey for socio-economic reasons. Population Control Act (Number 557, Nüfus Planlaması Kanunu) of 1965 encourages birth control, gives help to families through Population Control Clinics all over the country. Voluntary population control societies are also helpful.

Present population control policy of Turkey is: 1) To respect the human rights, 2) To improve the physical and mental healt and prosperity of present population, 3) To promote the idea that, each family shoul have as many children as they can feed, care and educate, 4) To help couples to determine the size of their families.

Ethical Problem occurs in birth control area for a physician when an unmarried girl, younger than 16 years old, asks the physician's

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help for contraception In this case, should a physician notify the parents of the girl? The answer is mostly «no». It possibly is better to reason the girl by showing the consequences to her that she herself should discuss this issue with her parents. We are afraid of the fact that knowing the contraceptive method and putting a device into the uterus or giving birth control pills may encourage the risk of promiscuity.

If a physician is against the birth control idea, he or she may feel free not to give advices to avoid pregnancy or abortion.

BIRTH CONTROL (CONTRACEPTIVE) METHODS :

1 — **Abstinence** from sexual intercourse is the most secure method but it is infallible.

2 — **Rhythm Method** (Natural family planning) is not to have sexual relations during ovulation time, namely around 14 days before the next menstruation. This method was almost the only one acceptable by Roman Catholic Church. it is not a secure method, especially if woman has irregular menstruation, after the recent child birth or miscarriage, during lactation and when the signs of menopouse start.

3 — **Coitus Interruptus** is the withdrowal of penis from the vagina before ejaculation. It is one of the contraceptive methods which was recommended by Hz. Muhammed. It is not reliable it needs strong self control of man, it creates frustration in the woman and tension and anxiety in the man.

4 — **Coitus Reservatus** is sexual intercourse without ejaculation. It needs stronger self control in men than coitus interruptus. It also creates frustration and anxiety.

5 — **Spermicides** are the chemical substances to kill sperms. Acacia barks which contains lactic acid is used by ancient Egyptians as a contraceptive. Spermicides are used as a pessary, cream, jelly and aeroso! forms, inserted into the vagina before the sexual intercourse. The failure rate is high.

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6 — **Condom** is a sheet of latex rubber worn over the penis during the intercourse. It also gives good protection to veneral diseases but it is unpleasant for both sexes because it dulls the sexual pleasure.

7 — **Diaphragm** is a rubber or plastic barrier covering the cervix and prevents the passage of sperms into the uterus. It has also some failure rate and distasteful to the woman.

8 — **Intra-Uterine Device (IUD)** is a coil or spiral or a loop which is inserted into the uterus to prevent conception. It has a small failure rate but it maybe expelled and the woman can not know it. It can cause irregular bleedings and possible cancer due to chronic irritation.

9 — **Synthetic Hormones** (Birth Control Pills) are used in woman for contraception. Although they are used as injections and implants but mostly they are taken as pills orally. Still there is no application of contraceptive hormons in men yet. Oral contraceptives are either progesteron alone or the cobnation of progestereon and oestrogen; they are very effective. Although there are some side effects such as thrombo-embolic disorders, oral contraceptives are relatively safe. Some hormones are used after sexual intercourse to avoid pregnancy, which are called «Morning-after-pills».

STERILIZATION

Sterilization is a process which causes a person unable of reproduction. Steril person is infertile or barren, not able to reproduce an offspring. Although total hysterectomy, irradiation and castration cause sterility, the term of sterility is usually used for vasectomy in men and tubal ligation in women.

Vasectomy is a simple surgical procedure which is done by cutting and ligating the two vasa differentia. This surgery avoids sperms to pass from testicles to uretra. There is no harm to the production of male sex hormone (testosterone); the man who had sterilization is able to perform sexual act normally; there is no harm to secondary sex characteristics.

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Tubal Ligation is done usually right after delivery by cutting and ligating both Fallopian tubes, either by a small incision in abdominal wall or by a laparoscope.

A small percentage of vasectomy but about 50% of tubal ligation are reversible with a skilled surgery. Namely, if the woman changes her mind, her reproduction maybe restored in half of the cases.

Sterilization maybe : 1) Voluntary or, 2) Compulsory.

Voluntary sterilization is performed with the request and consent of o person and creates less ethical and legal problems than compulsary one. Compulsary sterization is done regardless of whether the person wants it or not It was done in the ancient times for punitive reasons together with castration. Recently fine technics are developed to make a person sterile without castration. Compulsory sterilization was used in Nazi Germany to purify the race; it was also administered in India in 1960s for contraception if a family already had more than 3 children; in India the men were sterilized; there was a big reaction to this procedure and caused a riot.

The reasons for sterilization maybe, 1) Medical, 2) Socio-economic (contraceptive) or, 3) Eugenics.

1) **Medical indications for sterilization** are in certain genetically transmitted diseases such as Huntington's Chorea, hemophylia etc. or in the diseases which cause great harm to the patient if patient carries up pregnancy such as uncontrollable diabetes, heart failure, tuberculosis etc. or if a surgeon finds an unexpected dangerous illness during the surgery.

2) **Eugenic indications :** Eugenics is a science which applies genetic knowledge to practice in order to have physically superior generations. **Positive eugenics** encourages more reproduction of physically and mentally superior persons (Aristogenic), **negative eugenics** discourages the reproduction of inferior or disqualified persons (cacogenic). Eugenics was popular in the later part of 19.th century and early part of 20.th century. Many states passed laws for voluntary o· compulsory sterilization in order to promote a better race. Eugenics reached its peak in Nazi Germany.

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After we learned more on genetics and we were able to avoid the birth of genetically defected babies by abortion after amniocenthesis, and greater hopes in cloning, eugenics lost its importance. It is possible to diagnose defected babies through the tests in amniotic fluid. Besides, artificial insemination is also helpful to eliminate some of the defected births.

3) **Socio-economic (contraceptive) reasons :** Today sterilization is mostly done for contraceptive reasons both in men and women. It is a safe contraceptive measure. Although the semen could contain sperms after vasectomy, they disappear in 2-3 months. When the semen is free from sperms after a few semen examinations, the assurance can be given to the individual.

Legal and Ethical aspects of sterilization :

Some states passed the laws for compulsory sterilization for mentally retarded, sexual psychopaths and criminals and for some mental illnesses in early part of 20.th century. When we learned more on genetics, this practice have been done less frequently.

Compulsory sterilization in mentally incompetent and in minors create ethical and legal problems. When a state commits itself to take care of indigent people and dependent children, certainly it is going to take a heavy financial burden. For the sake of taxpayers' money, there should be a restriction of the births of mentally retarded children and the ones who will be a burden to society. This created a serious problem in the USA. After all we are able to diagnose many undesirable diseases during pregnancy through amniocentesis and if the test is positive, we may terminate the pregnancy.

Compulsory sterilization for contraception does not sound democratic; it did not work in India.

In the first glance voluntary sterilization seems ethical and does not violate human rights. However the physician should be very careful and should consider many possibilities before doing it.

Take a woman who has more children than she wants and who had a difficult delivery. At that time this woman wants tubal liga-

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tion. After the time passed, she may change her mind and in many cases restoration of fertility may not be possible. Or take a family who has several children but after sterilization all children were killed in an accident. Possibly taking and storing sperms and ova maybe recommended before sterilization.

In Turkey, Nüfus Planlaması Kanunu (No. 2827, 1983) and Rahim Tahliyesi ve Stelizasyon Hakkında Tüzük (No. 18255, 1983) allows sterilization as follows: «Sterilization surgery is done upon the request of an adult person if there is no medical contraindication». Article 13 of same Tüzük says: «A consent certificate from the spause is necessary for a sterilization surgery in a married person». According to same Tüzük sterilization surgery is done by a specialist or a certified general practitioner; sterilization surgey in women can be done only in official hospitals and in private hospitals. The Tüzük also mentions minimal requirements of these places.

To promote or «activate» the voluntary sterilization by a third person is possibly unethical. especially if this person is compensated with money or other means. It sound like brain washing.

Even the law gives the right to the person to have sterilization, the physician should look upon the following considerations:

1 — The person should be legally competent to give a conseni with free will and should understand the nature and consequences of the procedure.

2 — The physician should give all the comprehensive information about the possible consequences of the sterilization. The physician will also try the other contraceptive measures before the surgery.

3 — The spause of the candidate for sterilization should give a written consent too.

4 — Each partner should understand that sterilization will not be a reason for future divorse.

5 — The physician should take the necessary precautions to avoid future malpractice suits. It is advisable to take the decision of sterility to hospital sterilization committee.

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6 — Preferably the surgery should be delayed 2-3 days to give time for a second thought to his patient; he or she may change his or her mind.

CASTRATION

In broad sense, castration is the removal of sex organs, but mostly testicles and ovaries which are the sourse of male and female sex hormones. Sex hormones are the sourse of sexual libido and secondary sexual characteristics.

When castration is done after the puberty, maybe sexual libido disappears but the secondary sex characteristics are effected little. Castrated person is definitely steril. If castration is done before the puberty, **eunuchoidism** or **eunichism** develops, namely the secondary sexual characteristics of the opposite sex develop.

The eunuchoid man has narrow shoulders, hips, little or no beard and body hair and high pitched voice. The eunuchoid woman has male body proportions, is hairy as a man and has a deep voice

In old cultures and untill recently in the royal courts, the young boys were castrated for the sake of Harem; they were called «Eunuchs» or «Harem Ağaları» In the western cultures, castration in young boys were done in order to have high pitched boy's voice.

Compulsory castration is against human rights in contemporay cultures. Castration for punitive reasons was done in the past to punish the sexual offenders. This is also against to human rights.

Casration maybe performed for medical reasons, such as malignant tumors or some very rare hormonal diseases. Sometimes, it can not be possible to get the informed consent from the patient if a dangerous illness is diagnosed during the surgery. For instance, when a patient was having abdominal surgery for fibro-myoma with her informed consent, if a cancer is found in ovaries, castration is done without patient's consent in Turkey. No. 2827 act of 1983 on Population Control Law gives this right to the physician. In some countries, legislation allows the castration for incurable sexual criminals, but Turkey does not have such a law.

Voluntary castration in men has been a popular subject during the last decade when homosexuals were somewhat tolerated by law and society. Generally transexuals, transvestites and homosexuals asked for castration surgery. Transexuality is a strong desire to have the role of opposite sex. One of my male patients stated: «Doctor, my greatest wish is to please a man sexually». Some of them are schizophrenics.

A physician must be very careful on this surgery. The surgeon may have a very strong opposition from the society and from his colleagues.

The following recommendations may be adviced to physicians in the case of voluntary castration in men:

1 — The patient must be fully informed about the implications of the procedure.

2 — The patient must have full battery of psychological tests and psychiatric examination.

3 — A good hormonal studies and a complete physical examination is necessary

4 — This surgery should never be done on minors, mentally retarded and mentally ill.

5 — All the social and psychological conditions should be evaluated.

6 — Arter all above requirements are met, the case should be presented to the hospital castration committee. If there is no such a committee in your hospital, be sure to ask the administrator to establish this kind of a committee.

7 — Definitely obtain a written consent from the patient.

8 — It will be advisable to do the surgery at least one month after hospital committee's permission, because patient may change his mind during this time.

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PHYSICIAN'S POSITION IN TORTURE AND PUNISHMENT

According to Declaration of Tokyo torture is defined as «The deliberate, systematic or wanton infliction of physical and mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason».

Almost each physician will confront with the ethical problems of torture or punishment one way or other in his practice. The doctor may work as a police physician, government employed health director or officer in districts, in public health centers, in the courts directly or as an expert examiner or therapist indirectly. The physician can not help getting angry at the criminal or rapist as a member of society but he also knows that his first goal is to preserve, prolong, spare and comfort the patient. Like most of the fellow Intelligent men, doctor is against the torture of a man by another human being. Even you can not prevent the practice of torture, as a physician at least you should not be a helper in torture.

Police may ask you to learn secrets from the prisoner, you may be asked to find some ingenious ways to get confessions from criminals, even you may be asked to give poisons. What will be your position in hunger strikes or in executions?

Lackily almost every legislator tries to be helpful to physicians in the above mentioned conflicts.

The best and clear rules were put on in the Declaration of Tokyo by World Medical Association The following is the except from the Declaration of Tokyo :

1 — The doctor shall not participate in torture or other forms of cruel, inhuman or degrading procedures.

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2 — The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the torture and other inhuman practices.

3 — The doctor shall not be present during torture.

4 — The doctor will have complete independence in torture cases and his goal will be the physical and mental healt of prisoners.

5 — The physician shall not forcefully feed the hunger striker but should explain him the consequences of hunger.

6 — Other doctors and medical organizations will be encouraged to help the doctor who is forced to help torture against his will. (For complete text see appendix XI).

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THE RIGHT TO STRIKE OF MEDICAL PROFESSION

In order to get better payment or better working conditions, trade unions have the right to strike in democratic societies. Strikes could be done for political purposes too. Do the health workers have the right to strike? When we consider human rights, why the physicians can not strike? Physicians have trade unions too. But medical profession has a specific situation as armed forces, police, public utility workers etc. When these groups strike, all the society, including themselves, suffer greatly. Medicine has a unique position. If health workers strike, patients will suffer directly or indirectly; patients may die or minor illnesses may worsen to an irreversible point or an epidemic may spread. Certainly in this situation patients have justified reason to sue doctors for demage.

Probably the real problem is moral rather than legal in the strikes of health workers. Another question in the strikes by health workers comes from the fact that the employer generally is government in most of the courtries. This creates a problem. Sometimes it could be viewed as a rebellion rather than a strike.

Possibly partial strikes by healh workers may not be unithical such as the strikes of resident physicians for higher pays or better working conditions, the strikes of a group of physicians against overtime work or to refuse to sign certain certificates. No matter what is the motivation or type of strike by health workers, a full stoppage of work is not possible. Healt workers may refuse to take care of patients **except the emergency cases.**

Because of the unique position of medicine, the strikes by healt workers generally is not accepted as ethical.

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PRIORITIES AND SELECTIONS

Who Should be Served First?

Suppose you are an only surgeon in a battle front. Too many wounded soldiers were brought in for your services. Who are you going to save first? 1) Slightly wounded, 2) Seriously wounded who need immediate resuscitation or, 3) Hopelessly wounded? Your Immediate answer maybe to save the second group because if you do not resuscitate immediately the soldiers will die soon. But according to military regulations (in most of the armies of the world) you should save the less wounded soldiers first in order to send them back to fight. This sounds unfair and unethical but it is a fact since the **Triage** (Selection) system was established during the Napoleonic Wars.

I am sure you read stories or you have seen movies in which a ship is sinking; there is not enough life boats to save all passengers, some will definitely drown to death, others will be saved. In these cases, the captain of the ship says : «Children and Women are first».

There are many situations in medical practice in which a physician will be in extreme difficulty to decide «who shall live when not all can live?» such as utilizing dialysis machines, rare drugs, limited hospital beds, transplant organs, intensive care or coronary care unite facilities etc.

According to Declaration of Geneva (International Medical Oath) and to the Principles of Turkish Medical Association the physician will not permit consideration of religion, nationality, race, party politics or social standing to intervene between his duty and his patients. If you prefer one patient to the other one, you will

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lose the respect and trust of your patients and society. In many cases you will struggle with your duty, your pledge and your conscience.

Suppose you have only 3 heart-lung machines in a single hospital of a remote town. Two of them are in service of 2 middle aged persons and the third one is occupied by an old lady who is in coma for two weeks. A young man is brought into hospital who had a crushed chest in a traffic accident and needs a heart-lung machine immediately. Are you going to take the machine away from the old lady to save the life of the young men and allow the first one to die? Is it not a crime? It might not be for a Utilitarian because young man is more valuable to society than the old woman. But it might be unethical for a deontologist because every human being has equal rights.

Deontologists (Kantians) prefer a random selection such as either, 1) First come is first served or, 2) Whoever wins the lottery, namely whoever finds the unbroken straw or the head side of a coin.

There could be some unfairness in «first come is first served» principle because all needy persons can not get information at the same time; smart people could find ways to register their names first. Also lottery system may not be fair because many times all candidates can not come at the same time.

Utilitarian principle is to sacrifice less valuable ones for the sake of more valuable ones to society. But who is more valuable to society? Either a young scientist or an unskilled worker? How can we decide about this? Do we have criteriums on this matter?

Nicholas Rescher (at Munson([44])), a utilitarian, considers 3 areas for selections : 1) Is the person a member of the community the institution is designed to serve?, 2) Can new knowledge be gained from the case?, 3) Is the treatment of the person likely to be effective? Then he enumerates 5 factors in selecting cases for services : 1) The likelihood of successful treatment compared with others in the group; 2) The life expectancy of the person; 3) The person's family role; 4) The potential of the person in making future contributions; and, 5) The person's record of services or contributions.

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Jonsen-Siegler-Winsdale[50] offer the following guideline for a triage system : a) There should be an immediate and severe danger to the fabric of society, such that the threat to the society's survival is clear and present. b) The selection of certain persons on the basis of their position or skills should be based on the judgement that they will quickly return to their posts.

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QUACKERY

By Berhan TOSUNER, M.D.(*)

In taking the Hippocratic Oath the physician swears that «I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous. With purity and with holiness I will pass my life and practice my art».

Medicine is a noble art and should be practiced in a noble way. There is an old saying that the phycisian is someone who stands between God and the human being. Ruhavî,( ) a IXth centure A.D. moslem physician glorifies the qualities of the physician with these words : «Medicine is a profession given by God to those whose arts are pure, who have sharp intellect and who love goodness, have mercy, sympathy and chastity.»

Unfortunately there can be found some doctors who simply ignore all professional virtue and astray from honesty; practicing their art not for the benefit of the patients, but only for the benefit of themselves. This is quackery. The most unfortunate kind of qauckery is that wihch is practiced by the physician. We all know that for centuries quackery has been practiced and still is practiced by people who are not trained physicians but who claim that they can cure the sick. As long as they are not doctors their acts do not annoy us But, if a real physician acts like a quack, then he or she stains all his colleagues and the medical profession as a whole.

What is quackery or charlatanism?

Quackery is defined in the Encyclopaedia Britannica as (characteristic practice of quacks or charlatans who pretend to knowledge and skill that they do not posess, particularly in medicine).

(*) Berhan Tosuner, M.D. is a lecturer of Medical Ethics at Marmara University Medical School and Chief of clinic at Heybeliada Sanatoryumu; formerly a practicing Internist in the U.S.A.

In Webster's Dictionary quack is described as «One who with little or no foundation, pretends to have skill or knowledge in a particular field. — An untrained pretender to medical skill he does not possess, a fraudulant practitioner.»

Synonyms for quack are listed as «charlatan», «empric», «imposter», «mountebank» and «pretender».

Charlatan is a French word derived from the Italian word **Ciarlatano** which has the same meanings as quack. As a verb **ciarlare** is to engage in idle talk. As a name **ciarlatano** is one who makes untruthful pretentions.

Imposter is a deceiver using a false character.

Mountebank is one who mounts a bench or a stage in the market place or other plazas, boasts of his skill in curing diseases, vends quack medicines and attracts an audience usually by tricks, stories and jokes. Mountebank is also described as any boastful and false pretender.

For quack the Redhouse translation to Turkish is «şarlatan hekim, sahte doktor, şarlatan kimse».

In the old days an Arabic word in Ottoman language «Mütetabbip» or «Mutatabbip» was used to express these meanings. In Devellioğlu Dictionary mütetabbip is explained as «hekim taslağı, hekimlik taslağı», that is one who pretends to be a doctor yet he is not.

In the book of Bedi Şehsüvaroğlu - Arslan Terzioğlu quackery is defined as «practicing medicine by any possible means in order to get fame and wealth in a short period of time, that is cheating patients in professional way for substantial personal benefit.»

Quackery can be practiced by laymen, non-physicians as well as by physicians.

How can people without any medical training be engaged in quackery?

We have to realize that informative suggestions, recommendations or just a tender, loving, care by a person in whom we trust and believe may have some curative effect on the disease process and/or our morale. Praying by a hoca, sheikh, even an elderly lay person may decrease the intensity of the pain relax somewhat

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stress and even help improve some organic pathology. As we know, warts, (verruca vulgaris) may be healed simply by praying. Dervishes from Rufai order fall into a deep trance and ecstasy during their rituals and do not feel any pain while stubbing themselves with metal skewers.

People are most vulnerable to quackery in times of great stress, pain or sorrow. In the absence of exact knowledge, and sometimes even its presence in the face of insurmountable difficulties, the credulous person looks for a miracle. He is ready to be overwhelmed by the personality and claims of a charlatan. The conditions usually treated by quacks are those for which specific methods of treatment or cures have not yet been developed; those particularly feared such as cancer, venereal diseases and, in the past, tuberculosis; those with frequent remissions and recurrences such as arthritis and migrain; and mental disturbances.

In my higschool days, a man in Istanbul's Aksaray district used to sell pills for tuberculosis and he made a good living from it even though he did not have any medical training at all.

Üfürükçüs claim to cure by breathing. Lead readers (kurşun dökücüler) cure and make some diagnosis by looking at the figures which emerge by melted lead on a frying pan. Faith-healers (iman ile şifa vericiler) claim to cure their patients by putting their hands on the patient's body and by praying at the same time. Some of them even prefer to perform this healing ritual on the stage of big theaters or convention halls in the presence of a huge audience and television cameras.

Çıkıkçılar (discolation reducers) also do not have any medical training. Their secrets pass from father to eldest son. The son learns the techniques as an apprentice of his father.

Shamans or medicine-men also have no medical training. The shaman is a medicine man, priest and psychopomp. He cures sickness, he directs the rituals and communal sacrifices and he escorts the souls of the dead to the other world. He is able to do all these things by virtue of his techniques of ecstasy and by his power to leave his body at will. We should say that shamans are not charlatans because they are not doing these for their personal benefits.

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Quackery can also be practiced by some people who are somewhat related to the medical profession. A good example of this kind of quack is given in Prof. Emine Atabek's book. A man named Brinkley attended medical school only three years in the USA. Without any diploma, he opened an office in 1918 and engaged in medical practice. He advertised himself as a specialist in increasing the potency of manhood. He implanted the testicles of three-week-old male goats to his patient's bodies for a fee of 700 to 1500 dollars. A daily news paper, the Chicago Tribune, asked the ideas of well known physicians about this treatment. All agreed that his treatment was baseless and useless. Nevertheless his fame increased more and more. Patients swarmed around his office. In 1922 he started using a radio station and selling special male gonad syrup for 100 dollars a bottle. There were rumors that in 1925 he obtained a doctorate degree in Paris (without any exam.) and was even elected to the British Medical Association. He became a millionaire and very famous. In 1930 the Kansas State Medical Society conducted an investigation, and as a result his radio station was closed. However Brinkley simply moved to Mexico and opened his radio station and practice there. Finally, in 1942, the American Medical Association sued him in court. But this time he died of heart attack before the court hearing was started.

By this point we have illustrated non-physician quacks. Let us not forget that there are doctors with diplomas who practice quackery. I think the most unforgivable action of a physician is to practice his or her noble profession as a quack. There are doctors who use radioscope as a magic diognostic tool. With radioscopy they search not only the patient's chest but his head, brain, abdomen etc. In their hands radioscope is a multipurpose, incredible machine. There are doctors who give injections for any kind and every kind of disease and charge the patient for the size of the syringe and needle. There are doctors who use a **simsar** middle man. There are doctors who practice dychotomy «to refer the patient to another physician or physicians unnecessarily». There are doctors who use long news paper advertisements. These are punishable by law and by regulations of local chamber of medicine.

Here are the codes for medical practice and ethics related to quackery in Turkey (Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun).

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Code Nr : 1219

Article 1) Only diplomates of a school of medicine can practice and treat patients by any means at his (her) judgement.

«This law, obviously forbids all non-physicians, faith-healers, breath-healers, dislocation reducers from medical practice. This law also forbids chiropractors, osteopaths and homeopaths from practicing in Turkey although these professions are permitted in many countries».

Article 16) Board of Ethics of the Chamber of Medicine can discipline doctors who violate the professional code of ethics with the following penalties :

a) A written warning,
b) Warning in the presence of the whole assembly,
c) Temporary prohibition from the medical practice from one week to six months.

Article 24) With the exception of the address of his (her) medical office, working hours and speciality «and academic degrees if any» all other advertisements and publicity are forbidden.

Article 25) Any one who treats a patient without a medical diploma or claims to be a doctor can be punished with from one to six months in jail and 1000 to 1500 TL. cash penatly.

Here are the regulations related to charlatanism, quackery :

Nr : 10436

In accordance with the Regulations for the Turkish Medical Association (Nr : 6023) all physicians and dentists should obey these regulations.

Item 9) Same as Article 24 above.

Ithem 12) Doctors and dentists.

a) Can not engage in any acts which aim at obtaining an unjustifible benefit,
b) Can not send patients to other doctors and be payed in return for such referrals (Fee Splitting).
c) Can not pay pharmacists, medical personnel and any other third person for furnishing patients.
d) For personal gain or illegitimate profit can not prescribe medical devices or can not admit subjects to healt centers.

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MEDICAL MALPRACTICE

by Berhan TOSUNER, M.D.

In Webster's Dictionary, malpractice is defined as :

«a) Injurious or unprofessional treatment or culpable neglect of a patient by a physician or a surgeon,

b) Misconduct or improper practice in any professional or official position,

c) In general, wrongdoing, criminal practice, illegal or immoral conduct.»

The subject of medical responsibility or punishment for malpractice dated back to the times of Mesopotamian civilization. In Hammurabi's Law (1800 B.C.) these codes were written as :

Article 219) During treatment, if a physician causes opening a dangerous wound which results in the death of the patient, that physician could be subject to punishment. Equally, if there is an abscess close to the eye and if a physician causes an injury to the eye while opening the abscess with a bronze operation-knife then again he could be punished. This punishment typically means the cutting-off of both hands.

Article 220) If this patient is a slave the physician must replace him with a new slave.

Article 221) If a slave's eye is damaged, then the physician must pay half of his purchase price.

Here the main consideration is compensation for the result of the wrongdoing : Death, blindness.

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In ancient Egypt, if the physician obeyed the medical rules properly he was not held responsible for the bad results.

In ancient India, Manu and Zoroaster laws were in practice. According to Manu if a physician malpracticed he received a cash penalty. Zoroaster law was more cruel. It ordered death to the wrongdoing physician by cutting pieces off his body. However a jury of physicians decided whether or not he was guilty. This was the first expert witness committee in the history of law. Thus, it established a precedent for the concept of expert witness.

In the old Hellenic civilization ideas varied. According to Aristotle and Socrates physicians should be responsible for their deeds, while Plato advocated that physicians should be immune to penalties. In reality however in old Athens doctors were responsible for their negligence and imprudence.

In our times the physician is responsible and punishable for all the damages (death, bodily harm, incapacitating, financial damages) he caused during his practice, because of :

a) negligence, carelessness or causation with intention,

b) not following the proper rules for practicing medicine,

c) not applying the latest scientific methods for diagnosis and treatment,

d) lack of medical knowledge and training.

Alongside physicians, the health institutions, hospitals, laboratories and other related medical services are also jointly responsible if their practice is not proper.

Particularly in Western Europe and the United States of America law suits for medical malpractice are rapidly increasing in number. There are lawyers specializing in medical malpractice, cooperating and collaborating with physicians eager to expose their colleagues' faults. These lawyers and doctors are called «ambulance chasers», because after each ambulance passes they want to detect the medical mistakes in order to use them to get huge medical compensations. This is a new business, a new industry. This new industry has caused doctors to practice a new style of medicine :

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Defensive medicine. It means that doctors now order a bunch of laboratory tests, X-ray examinations for even simple headaches or chest pains. This attitude of course increases the medical costs and hospital expenses have gone sky high. On the other hand, the increasing number of law suits and many court rulings against physicians as well as many out-of-court settlements also cause a tremendous increase in the premiums of physicians' malpractice insurances. Anesthesiologists, neuro-surgeons and Gynecologists pay the highest premium, about 50.000 dollars per year. This increases in overhead of the doctor's office is surely reflected in the doctor's fee.

I would like to mention some of the malpractice suits.

A lady with the suspected breast cancer was taken to the surgery. The suspected node was removed and sent to the pathology laboratory for quick diagnosis by means of frozen seçtion. This was done and early diagnosis from lab, was malignant tumor. This was explained to the patient's husband and with his permission her breast was removed. (Patient herself had also signed a pre-operation permit indicating that if frozen seçtion is positive for malignancy, the doctor should go ahead and perform the necessary surgery).

However, later on several regular tissue examinations were performed and none of them revealed any malignancy. The early report of frozen section was a laboratory techinacl error.

In this case, the surgeon, the pathologist and the hospital were all sued because of disfiguration of the patient and they had to pay an enormous sum of money.

A patient reported to the emergency room with the complaint of left sided chest pain. X-rays revealed pneumonia. The patient was admitted to the hospital in a regular medical floor and was treated for his pneumonia. The pneumonia improved. However, the patient died on the fourth day of admission of a sudden massive myocardial infarction. In this case, the admitting emergency room physician and the treating internist and the hospital were sued for missing an underlying heart ailment and not treating it properly.

Tetracycline group antibiotics were freely used for many years in small children and pregnant women until it was found that these drugs can cause dental problems in infants and children. This dis-

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covery triggered many law suits against the doctors who prescribed tetracycline and against the manufacturing company.

The same thing can be said for the excess use of the oxygen to save the life of the new born babies. This can cause retro-lental fibroplasia and consequentiy blindness. The result is many law suits.

Research suggest that every third doctor will be sued in the next five years in the USA. Again, in one out of four deliveries, the obstetrician will go to court for some reasons.

In order to prevent a suit, doctor should :

1) practice honestly, openly and apply appropriate medical rules,
2) treat the patient with up-to-date medical knowledge,
3) keep very good medical records,
4) explain all the details for surgery and any invasive procedures, ask the patient to sign a consent form.

An example of the informed consent form is as follows :

(I, ..., being fully conscious, give consent to Dr. ....., to perform the necessary surgical operation for the tratment of my disease. I also give permission for any other necessary operations in case of complications during my surgery. I was informed by the doctor about dangers).

Witness Signature

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CONSULTATIONS

by Berhan TOSUNER, M.D.

Among practicing physicians consultation means attending physician's conference with one or more colleagues in order to discuss his «her» patient's condition and get their advice.

When is a consultation necessary?

a) If a reasonable time has elapsed yet no healing has occured,

b) If a complication interferes and worsens the disease process,

c) If the disease is uncurable one and is becoming grave a consultation is proper.

In addition, some families like to have a consultation even at the beginning of any illness because they feel more secure this way. Some categories of the society take the consultation as a status symbol or a good way of showing off.

Consultation is a very old medical procedure. Even in ancient times physicians were invited to foreign countries for consultations. Mesopotamian, Sumerian and Egyptian doctors went to other neighboring states to cure the sick. Story of İbni Sina's (Avicenna) famous consultation is very well remembered in our times. The grand son of the Emîr of Rey and Taberistan had become ill. No one of the Emîr's doctors could diagnose the disease. Then they invited İbni Sina for consultation (XIth century A.D.) He found out that the prince was helplessly in love and to be cured he should get married to the girl he loved. And it worked.

Here are the rules in the Medical Ethics Regulations (related to consultation) which were adopted in January 1960.

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Item 24) Should a patient request that a consultation be done, the attending physician must accept it.

If the attending physician thinks that a consultation is necessary he «she» informs the patient (or patient's family) about this necessity. Should the patient does not accept this consultation proposal then the attending physician can stop taking care of him «her».

Item 25) The consultation discussions and deliberations should be held in a room where the conversation can not be heard by the patient and the members of the family. During the discussions the dignity of the medical profession should be unblemished. Consulting physicians should avoid unnecessary, long, praising talks. Every one should express his opinion freely.

Item 26) The results of the consultation should be written on a paper and should be signed by all the participating physicians. The patient should be informed about the result by the most senior physician in the group. This explanation should be free of depressing, annoying words, vague and dubious phrases. Should be clear and simple.

Item 27) If the consulting physician feels that the present treatment is not proper, he «she» writes his thoughts on the consultation paper but does not give any orders to change the treatment.

Item 28) If the consulting physician and the attending physician are not in agreement and the patient accepts the consulting physician's recommendations, then the attending physician can stop taking care of the patient.

Item 29) Consulting physician can not treat the patient. The consulting physician can not visit the patient again without the attendig physician's request or permission.

Item 30) After the consultation, fees are given to each physician separately. Giving the sum and dividing it among the consultants later is not proper. The attending physician's fee will be more or less equal to what consultants are customarily given on this special occasion.

If the patient is in a hospital or health center, consultation can be done at the bed-side of the patient for physical examination. La-

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ter discussions can be done in the attending or consulting physician's hospital office or any other proper, avaliable room. In some cases, the patient is sent to the consulting physician's ward or office or an out-patient cilinic. In some hospitals, cases are presented in regular medical conferences.

Nowadays in the USA house-calls by physicians are rare. Therefore consultations usually accomplished merely by sending the patient to the consultant's office.

In hospitals for in-patients, the attending physician usually gives a call to the consulting physician and also writes the orders on the order-sheet of the patient's hospital chart, requesting a consultation with this given consulting physician. By his writing he clarifies how much authority the consultant can exersize, as follows :

a) Consultation only, without writing any orders,

b) Consultation, with consulting physician writing orders which are subject to attending physician's approval,

c) Consultation, with consulting physician writing the orders freely (without approval by attending physician)

d) Consultation and to follow (the patient to be followed freely by consultant physician)

In the I.C.U. (Intensive Care Unit) and the C.C.U. (Coronary Care Unit) relations between attending and consulting physicians are somewhat different. A specialist or sub-specialist (consulting) and a family physician or specialist (attending) take care of the patient jointly until the patient's condition improves to the point where the attending physician can continue alone, without any danger to the patient. This point is decided upon by the consulting physician.

MAIN SOUOCES FOR QUACKERY, MEDICAL MALPRACTICE AND CONSULTATION

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2 — Devellioğlu : Osmanlıca - Türkçe Ansiklopedik Lügat. Kurtuluş Ofset Basımevi, Ankara, 1984.

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5 — Şehsüvaroğlu, Bedi N. - Terzioğlu, Arslan : Tıbbi Deontoloji, Istanbul Tıp Fak. Vakfı. Bayda Yayınevi, 2.nd Print., Istanbul 1983.

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APPENDIX : I

TURKISH MEDICAL ETHICS REGULATION
(TIBBİ DEONTOLOJİ TÜZÜĞÜ)

(T.C. Resmi Gazete. 19 Febr. 1960 No. 10436)

Article 1 : Ethical rules and regulations of physicians and dentists are shown in this regulation. Member physicians and dentists of local chapters of the Turkish Medical Association are under the juristiction of article 7 of No. 6023 Act.

SECTION : I.

Article 2 : The first duty of a physician and dentist is to care and respect human life, health and personality, no matter what the sex, race, nationality, religion or denomination, moral volues, character or personality, social status, educatinal level and political beliefs.

Article 3 : The physician should take care of emergency cases no matter what his official duty and speciality in desperate situations.

Article 4 : A physician or dentist cannot reveal the confidentialty of a patient unless he is forced by law.

Article 5 : :A patient is free to choose his physician or dentist although certain health facilities may have their own rules.

Article 6 : While he is performing his profession, a physician or dentist must act according to their conscience and opinion. They are free to determine their own method in treatment.

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Article 7 : Physicians and dentists must avoid unethical conduct even in areas other than medical practice to protect the integrity and honor of medicine.

Article 8 : The medical and dental profession should not be a commercial issue. In his publications, a physician and dentist must protect the professional dignity. He cannot advertice himself in his publications.

A physician and dentist cannot allow patients to express their gratitude in the news media.

Article 9 : Physicians and dentists cannot advertise in news media and in their prescriptions other than their names, address, specialty as defined by regulations, their academic title, days and hours of their work.

The size, number and shape of their signs, inside or out, should be regulated by local medical societies. Not more than 2 colors can be used in signs; they cannot be illuminated by light.

Article 10 : A research physician cannot apply diagnostic and therapeutic methods which he invented to his patients unless he is confident of its good effects and there is no serious side effects after several in-vitro and in-vivo trials. He should notify the proper authorities about precautions, making it sure that it is on trial period. No misleading statements should be used.

Article 11 : No surgical procedure can be done for research purpose, nor any physical, chemical or biological experiment and diagnosis.

If a traditional mode of tratment is believed to be useless a new method may be applied after enough and acceptable animal experiments. In order to apply this new method, it is necessary to know that the new method is beneficial and at least not worse than the old one. If there is no other way to help the patient, a new untried method may be used, if there is no possible harm, in order to save the patient.

Article 12 : Physicians and dentists

A — Cannot perform any procedures on patients to obtain unjust benefit.

B — Cannot ask or offer a benefit in their referring cases to each other. (Fee splitting).

C — Cannot offer any compensation to pharmacists or ancillary medical personnel or anybody for the referral of patients.

D — Cannot recommend any drug, medical gadget or tools to patients for unlawful personal benefit, and cannot refer or admit patients for same reasons

E — Cannot accept a third person's mediation to determine fees for diagnosis and treatment.

SECTION : II . **The Relations with Patients :**

Article 13 : A physician or dentist makes his diagnosis and treatment in accordance with scientific principles. He cannot be critisized ethically when the illness is not perfectly cured if he did his best.

Deceptive diagnosis and treatment against medical principles and rules are prohibited.

A physician cannot do any diagnostic or therapeutic procedure which decreases the physical and mental strenght of the patient in order to please him.

Article 14 : A physician and dentist must give necessary care to their patients. Even he connot save the patient's life, at least the physician could try to decrease or stop the patient's pain and misery.

A physician and dentist should give hope to their patients. If he believes that the bad news about the prognosis of the disease does not worsen his patient's condition, he should tell the truth openly on diagnosis in order to take proper precautions. However, it is recommended that the physician should not tell the patient about a potentially fatal outcome

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A hopeless prognosis may be hinted at with great precaution. Such a prognosis may be revealed to a patient's family if the patient did not ask not be revealed.

Article 15 : A physician also tries prevention when he is called for examination in a patient's home or other places. The physician informs the patient and the people around him about their responsibility of their environment.

A physician tries to show the patient his or her responsibilities for hygienic and preventive rules, even at the expense of losing his patient.

Article 16 : A physician or dentist writes his report on his patient according to his own observations and to his conscience and scientific belief.

No report or any other document may be given for a personal purpose or to please his patient.

Article 17 : A physician and dentist cannot interfere with their patient's personal and family affairs. However, every possible help and support should be given in life threatening cases.

Article 18 : A physician and dentist may refuse to take care of a patient for personal or professional reosons except in emergency cases, in official duties and for humane reasons.

Article 19 : A physician and dentist may quit his treatment for personal or professional reasons. However, he should give enough time to his patients to find another doctor carry on the treatment. If there is a possibility of a life threatening situation, they cannot leave the patient before finding another colleague.

A physician and dentist have to give his notes and observations to a patient if he finds it necessary or the patient wants them.

Article 20 : A physician and dentist need not give any medication to a patient if he believes it is useless. However, some medications may be given for consolation if there is no possibility of treatment.

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Expensive placebos should not be given to partients in financial difficulty if there is no absolute necessity.

A physician and dentist should not recommend any treatment method which is beyond the patient's financial ability and not really necessary.

Article 21 : A surgeon, family physician or dentist are free to choose their assistants in surgical and other procedures.

The fee of assistants is paid by the patient except in piece-rate prices.

A family physician or dentist cannot ask for compensation for attending the surgery if patient did not request his presence.

All rights are reserved for the health organizations which are financed by general, subsidiary or private funds, municipalities or other establishments under their juristictions.

Article 22 : Abortion is allowed only in cases where it is necessary to save the mother's life. If the mother's life is in serious danger and she needs surgical or other procedures to terminate the pregnancy, these procedures cannot be done without a certificate of two expert physicians or in their absence just two doctors', who must rely on objective evidence. The original copy of the certificate is kept by the physician who performs the abortion, and the other copy is sent to a local medical association by certified mail. This will later be certified by the performing doctor but will not contain the name of the mother.

The date and place of the abortion should be addded to the certified copy.

In serious and emergency cases where other physicians' certificate cannot be obtained, the physician acts independently but informs the local medical association with a certified letter.

Written consent of the patient and her guardian (if avaliable) must be obtained.

When the abortion is performed in the establishments mentioned in article 21, it is under regulation of those institutions.

(*) After these regulations adopted the law on abortion changed in 1983. See «Abortions» Page 113.

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Article 23 : The physician must try to save the mother and child in difficult labors. The physician carries out scientific and technical requirements without consideration of family and other reasons.

Article 24 : A family physician and dentist accept the patient's request for consultation.

If a family physician and dentist feels the necessity of consultation, they inform the patient about this. If the patient does not accept this resommendation, they may terminate treatment.

Hospital regulations define how and when consultations are done in the institutions mentioned in article 21.

Article 25 : Discussions and delibertations on consultations are done in a fashion that the patient and his family cannot hear or understand.

Professional dignity should be carefully taken into consideration during discussions and deliberations in consultations.

The consultant should tell his opinion frankly without a second thought such as protecting or praising his colleague or for other emotional reasons.

Article 26 : The results of the consultation are written down and signed in a report.

The results of the consultation are revealed by the senior consultant. This should be clear and should not disturb the feelings of the patient and the people around him.

Article 27 : If a consultant thinks the present treatment is not right, he writes his opinion only; he cannot interfere with therapy.

Article 28 : In case there is a discrepancy between the consultant and the family physician and if the latter insists on his opinion and the patient prefers the consultant's opinion, the family physician may leave the patient.

Article 29 : A consultant cannot treat the patient unless the patient insists upon it. A consultant should not attend the patient for the same illness before the permission of the patient's family physician.

Article 30 : Each consultant charges a patient seperately. Fees should not be taken and split among consultants.

A family physician has the same rights as the consultant in collecting fees.

Article 31 : The physician and dentist should not accept the fees less than the defined minimum charges in regions where minimum charges are fixed.

Article 32 : It is recommended that physicians an dentists should not charge to their colleagues or their dependents However, they may ask for indispensable expenses.

Article 33 : A fixed fee may be asked for surgical intervention, delivery, physical therapy, radiotherapy, dental treatment and for treatments which require follow up care

A fixed fee may be asked in a treatment center or establishment. A fixed fee is not permissible for other treatments except the above mentioned cases.

All rights are reserved for the fees in the places mentioned in

Article 21.

Article 34 : If treatment is terminated for any reason before it is completed in the cases in which contract price is permissible, the family physician charges only for the time he spent untill that moment; if he was paid in advance, he must pay back the proportional part of the money he received

Article 35 : In emergency cases, the physician and the dentist may ask for their fees later.

Article 36 : Physicians and dentists working in the places mentioned in Article 21 of this regulation cannot ask the patients seen in those establishments to come into their private offices and cannot charge them seperately.

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SECTION III: Colleagues' Relations with each other and Ancillary Personnel

Article 37 : Physicians and dentists should maintain their good professional relationship with each other and help each other. They should try to solve their professional disagreements among themselves first. If they are not successful, then they should report to the local chapter of their association.

Article 38 : A physician or dentist should not criticize his colleagues nor should he belittle them. A physician or dentist protects his colleague's dignity to others.

Article 39 : Physicians and dentists should not take away (entice) their collegue's patients.

Article 40 : Physicians and dentists should not violate the independence of paramedical people, should treat them kindly and should not put them in trouble with their patients.

SECTION IV: Miscellaneous Rules

Article 41 : Every year in early January, the local chapters of medical association must prepare lists of their members with their names and addresses.

Article 42 : Physicians and dentists have to notify to local chapters within one week after they open their office or laboratory, and also one week after they close or relocate them. This should be in writing.

Article 43 : A physician or dentist cannot make another colleague work for him in his office. However, they could leave their office to another colleague temporarly when they are away. They must notify local chapters when this time is more than one month.

Article 44 : The Board of Directors of local chapters are responsible for disciplining physicians and dentists in their court of honor when they disobey regulations in accordance with Article 30 of Turkish Medical Association Law No. 6023. In addition to disciplinary action, physicians and dentists may be punished by law.

Article 45 : These regulations which are prepared in accordance with subsection (g) of article 59 of the Law No. 6023

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are effective two months after their publication in Resmi Gazete.

Article 46 : The decrees of these regulations are executed by the Ministers of Justice and Health and Social Welfare.

APPENDIX II

CONSTITUTION OF THE WORLD HEALTH ORGANIZATION

The States Parties to this Constitution declare, in conformity with the Charter of the united Nationas, that the following principles are basic to the happiness, harmonious relations and security of all peoples :

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

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Governments have a responsibilty for the healt of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Accepting these principles, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

APPENDIX III

DECLARATION OF LISBON

(RIGTS OF THE PATIENT)

(World Medical Association 1981)

Recognizing that there may be practical, ethical or legal difficulties, **a physician should always act according to his/her conscience and always in the best interest of the patient.** The following Declaration respresents some of the principal rights which the medical profession seeks to provide to patients.

Whenever legislation or government action denies these rights of the patient, physicians should seek by appropriate means to assure or to restore them.

a) The patient has the right to choose his physician freely.

b) The patient has the right to be cared for by a physician who is free to make clinical and ethical judgements without any outside interference.

c) The patient has the right to accept or to refuse treatment after receiving adequate information.

d) The patient has the right to expect that his physician will respect the confidential nature of all his medical and personall details.

e) The patient has the right to die in dignity.

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f) The patient has the right to receive or to decline spiritual and moral comfort including the help of a minister of an appropriate religion.

APPENDIX IV

DECLARATION OF HELSINKI

(GUIDES IN BIOMEDICAL RESEARCH ON HUMAN BEINGS)

(1964 at Helsinki, revised at Venice 1983)

It is the mission of the medical doctor 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 diaagnostic or therapeutic value to the person subjected to the research.

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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 remomendations 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 laws 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 the 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

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the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6 — The righ 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 personalty 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 inversigation 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 witdraw 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 campletely independent of this official relationship.

11 — In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with

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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 concent, 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 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 judgment 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 advantage 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.

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III Non-therapeutic biomedical research involving human subjects (Non-cilinical 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 wellbeing of the subject.

APPENDIX V

THE NURENBERG CODE

(HUMAN EXPERIMENTS)

(1947)

The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably welldefined bound, 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

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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.

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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.

APPENDIX VI

MEDICAL SECRECY

(World Med. Assn. 1973)

"WHEREAS : The privacy of the individual is highly prized in most societies and widely accepted as a civil right; and.

WHEREAS : The confidential nature of the patient-doctor relationship is regarded by most doctors as extremely important and is taken for granted by the patient; and

WHEREAS : There is an increasing tendency towards an intrusion on medical secrecy;

THEREFORE BE IT RESOLVED: that the 27th World Medical Assembly reaffirm the vital importance of maintaining medical secrecy not as a privilege for the doctor, but to protect the privacy of the individual as the basis for the confidential relationship between

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the patient and his doctor; and ask the United Nations, representing the people of the world, to give to the medical profession the needed help and to show ways for securing this fundamental right the individual human being.•

APPENDIX VII

USE OF COMPUTERS IN MEDICINE

(WMA 1973, Amendm. 1983)

The World Medical Association, having taken note of the great advances and advantages resulting from the use of computers and electronic data processing in the field of health, especially in patient care and epidemiology, makes the following recommendations:

1 — National medical associations should take all possible steps to ensure the privacy, the security and confidentiality of information on their patients;

2 — It is not a breach of confidentialty to release or transfer confidential health care information required for the purpose of conducting scientific research, management audits, financial audits, program evaluations, or similar studies, provided the information released does not identify, directly or indirectly, any individual patient in any report of such research, audit or evaluation, or otherwise disclose patient identities in any manner;

3 — National medical associations should oppose any effort to enact legislation on electronic data processing which could endanger or undermine the right of the patient to privacy, security and confidentiality. Effective safeguards against unauthorized use or retransmission of social security numbers and other personal information must be assured before such information enters the computer;

4 — Medical data banks should never be linked to other central data banks.

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APPENDIX VIII

DECLARATION OF SYDNEY

(DETERMINATION OF DEATH)

(WMA 1968, Amendm. 1983)

1 — The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually the physician will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.

2 — Two modern practices in medical, however, have made it necessary to study the question of the time of death further: (a) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (b) the use of cadaver organs such as heart or kidneys for transplantation.

3 — A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed.

4 — It is essential to determine the irreversible cessation of all function of the entire brain, including the brain stem. This determination will be based on clinical judgment supplemented if necessary by a number of diagnostic aids. However, no single technological criterion is entirely satisfactory in the present state of medicine nor can any one technological procedure be substituted for the overall judgement of the physician. If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immedia-

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tely concerned with the performance of the transplantation.

5 — Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation and in countries where the law permits, remove organs from the cadaver provided that prevailing legal requirements of consent have been fulfilled.

APPENDIX IX

DECLARATION OF VENICE

(TERMINAL ILLNESS) (WMA 1983)

1 — The duty of the physician is to heal and, where possible, relieve suffering and act to protect the best interests of his patients.

2 — There shall be no exception to this principle even in the case of incurable disease or malformation.

3 — This principle does not preclude application of the following rules:

3.1 The physician may relieve suffering of a terminally ill patient by withholding treatment with the consent of the patient or his immediate family if unable to express his will. Witholding of treatment does not free the physician from his obligation to assist the dying person and give him the necessary medicaments to mitigate the terminal phase of his illness.

3.2 The physician shall refrain from employing any extraordinary means which whould prove of no benefit for the patient.

3.3 The physician may, when the patient cannot reverse the final process of cessation of vital functionas, apply such artifical means as are necessary to keep

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organs active for transplantation provided he acts in accordance with the laws of the country or by virtue of a formal consent given by the responsible person and provided the certification of death or the irreversibility of vital activity had been made by physicians unconnected with the transplantation and the patient receiving treatment. These artifical means shall not be paid for by the donor or his relatives. Physicians treating the donor shall be totally independent of those treating the recipient and of the recipient himself.

APPENDIX X

DECLARATION OF OSLO
(THERAPEUTIC ABORTION)

(WMA 1983)

1 — The first moral principle imposed upon the physician is respect for human life from its beginning.

2 — Circumstances which bring vital interests of a mother into conflict with the vital interests of her unborn child create a dilemma and raise the question whether or not the pregnancy should be deliberately terminated.

3 — Diversity of response to this situation results from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected.

4 — It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the physician within society.

5 — Therefore, where the law allows therapeutic abortion to be performed, the procedure should be peformed by a

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physician competent to do so in premises approved by the appropriate authority.

6 — If the physician considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague

7 — This statement, while it is endorsed by the General Assembly of the World Medical Association, is not to be regarded as binding on any individual member association unless it is adopted by that member association.

APPENDIX XI

DECLARATION OF TOKYO (TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMET)

(WMA 1975)

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1 — The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or

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guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2 — The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3 — The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4 — A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose.

5 — Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially The decision as to capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6 — The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctor, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

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APPENDIX XII

DECLARATION OF HAVAII

(A STATEMENT OF THE WORLD PSYCHIATRIC ASSOCIATION ISSUED AT THE SIXTH WORLD CONGRESS IN HONOLULU 1977)

Ever since dawn of culture ethics has been an essential part of the healing art. Conflicting loyalties for physicians in contemporary society, the delicate nature of the therapist-patient relationship, and the possibility of abuses of psychiatric concepts, knowledge, and technology in actions contrary to laws of humanity all make high ethical standards more necessary than ever for those practising the art and science of psychiatry.

As a practitioner of medicine and a member of society, the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the social duties of every man and woman.

A keen conscience and personal judgement is essential for ethical behaviour. Nevertheless, to clarify the profession's ethical implications and to guide individual psychiatrists and help form their consciences, written rules are needed.

Therefore, the General Assembly of the World Psychiatric Association has laid down the following ethical guidelines for psychiatrists all over the world

1 — The aim of psychiatry is to promote health and personal autonomy and growth. To the best of his or her ability, consistent with accepted scientific and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources.

To fulfil these aims requires continuous research and continual education of health care personnel, patients, and the public.

2 — Every patient must be offered the best therapy available and be treated with the solicitude and respect due to the dignity of all human beings and to their autonomy over their own lives and health.

The psychiatrist is responsible for treatment given by the staff members and owes them qualified supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help or the opinion of a more experienced colleague.

3 — A therapeutic relationship between patient and psychiatrist is founded on mutual agreement. It requires trust, confidentiality, openness, co-operation, and mutual responsibility. Such a relationship may not be possible to establish with some severely ill patients. In that case, as in the treatment of children, contact should be established with a person close to the patient and acceptable to him or her.

If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

4 — The psychiatrist should inform the patient of the nature of the condition, of the proposed diagnostic and therapeutic procedures, including possible alternatives, and of the prognosis. This information must be offered in a considerate way and the patient be given the opportunity to choose between appropriate and available methods.

5 — No procedure must be performed or treatment given against or independent of a patient's own will, unless the patient lacks capacity to express his or her own whishes or, owing to psychiatric illness, cannot see what is in his or her best interest or, for the same reason, is a severe threat to others.

In these case compulsory treatment may or should be given, provided that it is done in the patient's best interests and over a reasonable period of time, a retroactive informed consent can be presumed, and, whenever possible, consent has been obtanined from someone close to the patient.

6 — As soon as the above conditions for compulsory treat-

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ment no longer apply the patient must be released, unless he or she voluntarily consents to further treatment.

Wehenever there is compulsoıy treatment or detention there must be an independent and neutral body of appeal for regular inquiry into these cases. Every patient must be informed of its existence and be permitted to appeal to it, personally or through a representative, without interference by the hospital staff or by anyone else.

7 — The psychiatrist must never use the possibilities of the profession for maltreatment of individuals or groups, and should be concerned never to let inappropriate personal desires, feelings, or prejudices interfere with the treatment.

The psychiatrist must not participate in compulsory psychiatric treatment in the absence of psychiatric illness. If the patient or some third party demands actions contrary to scientific or ethical principles the psychiatrist must refuse to co-operate. When, for any reason, either the wishes or the best interests of the patient cannot be promoted he or she must be so informed.

8 — Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient releases the psychiatrist from professional secrecy, or else vital common values or the patient's best interest make disclosure imperative. In these cases, however, the patient must be immediatley informed of the breach of secrecy.

9 — To increase ond propagate phychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when case history is published, and all reasonable measures be taken to preserve the anonymity and to safeguard the personal reputation of the subject.

In clinical research, as in therapy, every subject must be offered the best avaliable treatment. His or her participation must be voluntary, after full information has been

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given of the aims, procedures, risks, and inconveniences of the project, and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study.

For children and other patients who cannot themselves given informed consent this should be obtained from someone close to them.

10 — Every patient or research subject is free to witdraw for any reason at any time from any voluntary treatment and from any teaching or research programme in which he or she participates. This withdrawal, as well as any refusal to enter a programme, must never influence the psychiatrist's efforts to help the patient or subject.

The psychiatrist should stop all therapeutic, teaching, or research programmes that may evolve contrary to the principles of this Declaration.

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MARMARA ÜNİVERSİTESİ 1883
MARMARA
ÜNİVERSİTESİ

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ERROR SHEET

Page	Line	Error	Correct
1	1	INTORDUCTION	INTRODUCTION
1	2	challengging	challenging
1	23	belive	believe
2	28	fhuman	human
3	20	trere	there
6	18	tfe	the
6	23	teJbook	textbook
7	21	taughth	taught
9	10	sholdd	should
11	17	enxiety	anxiety
13	26	es	as
13	28	mpments	moments
13	31	o	a
14	5	becoms	becomes
15	11	hepl	help
15	27	shoul	should
15	31	evnvious	envious
15	37	giren	given
16	3	lhildreen	children
17	8	baskgraund	backgraund
18	12	patients	patients
18	21	calls	calls
19	8	rite	write
20	29	thorouhly	thoroughly
21	35	persoonal	personal
22	14	explantation	explanation
23	28	Ethles	Ethics
25	10	too	to
28	32	shoult	should
29	32	healding	healing
31	14	unthical	unethical
32	11	greates	greatest
40	4	governmend	government
51	15	THERAPIS	THERAPIES
55	25	palent	patient
59	10	dentities	identities
84	27	cannt	cannot
86	14	efforte	efforts
87	33	unhappinesss	unhappiness
88	13	filled	filed
94	11	abodminal	abdominal

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Page	Line	Error	Correct
97	9	newbor's	Newborns
97	14	uTrkey	Turkey
99	29	parfiatly	partially
104	1	s	is
105	27	define	defines
107	29	decribe	describe
110	8	In	in
111	1	In	Is
113	33	permissiple	permissible
115	15	ta	to
116	6	there	three
120	5	techique	technique
120	35	rulet	ruled
123	13	shoul	should
124	26	.In	in
125	1	this a	this is a
126	34	shoul	should
128	18	cobnation	combination
128	18	progestereon	progesteron
129	10	o	a
129	12	not	not.
131	18	sound	sounds
131	21	consent	consent
132	24	casration	castration
133	23	Arter	After
134	25	except	excerpt
135	6	healt	health
136	12	Certainly	Certainly
136	19	unithi-	Unethi-
136	26	healt	health
139	1	Winsdale	Winslade
140	18	wihch	which
142	16	higschool	highschool

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MARMARA ÜNİVERSİTESİ

Marmara Üniversitesi Kütüphane ve Dokümantasyon Daire Başkanlığı

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