

## Medical Ethics — Past and Present

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### Summary:

Medical ethics is crucial to the practice of medicine as an honourable profession. In this article it is presented at two levels; the ideological, which is not for all to come upto and has in fact scared off many of our younger people from the profession, yet it remains a necessary inspiration for higher spiritual goals; the practical, middle of the road level is for all to strictly observe at all times. It is brought out herein that the Hippocratic Oath as such is now archaic, that contrary to popular belief, it has seldom been actually administered. Yet its spirit which reflects the profundity of human values is still alive or should be. Medicine is international and hence its ethical values are best presented in terms of a common moral language without incursion into religion except where necessary.

Medical ethics is now a discipline on its own. Not only books have been written on it but now journals too feature it. At least one is devoted to it exclusively. I do not claim to have read all these and my knowledge is admittedly patchy. I have relied on what I inherited from my teachers some of whom were role models for me and the sources on which I based my brief lectures on the subject to undergraduates during my teaching career. Added to this is a lifetime of personal experience which includes some knowledge of recent developments in this field.

An attempt will be made to deal first with

### THE PAST

Most discussions on medical ethics usually start with the Hippocratic Oath<sup>1,2,3</sup>, because it was in Hippocratic times that medicine became a science<sup>2</sup> and rose to a high pedestal because of Hippocrates and his oath. Its translation is reproduced below:

"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 who taught me this art; to live in common with him and if

necessary to share my goods 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 master 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 procure abortion. But I will 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 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 commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, 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".

It is known to most doctors and even to some of the educated laity. What is generally not known is that

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historians do not all agree that it was all written by Hippocrates himself<sup>4</sup>. Nor indeed it is agreed that it was actually administered<sup>4</sup>. According to Douglas Guthrie (1957)<sup>3</sup> the Oath was a charter or ideal, not in any sense a law. It was an appeal not a threat and no penalties were mentioned. Almost two thousand and five hundred years after it was written let us see what has relevance today and what has not<sup>5,6,7,8,9</sup>.

### 1. Belief in Greek Mythology

Obviously no longer relevant; this part could be replaced by the individual religions we believe in, or preferably, to make it universally applicable, base it on neutral moral values whatever our religion. This is the feature of the Declarations emanating from the World Medical Association (W.M.A.) in 1948, 1949, 1968 and 1983. The four main principles of medical ethics developed in America by Beauchamp and Childress<sup>10,11</sup> and their scope of application also provide a neutral ground on which we can all stand and take decisions using a common moral language. There are four common, basic *prima facie* moral commitments—respect for autonomy, beneficence, non-maleficence, and justice<sup>11</sup>. Space does not permit amplification of these here. We shall have reason to refer briefly again to these later.

### 2. Obligations to the Teacher

Still applicable though obviously not as much as in the Oath

### 3. The Concept of Medicine as a Restricted Closed Society

Not applicable. The profession now is or should be open to all on merit, inclusive of evaluation of character and motivation.

### 4. Obligations to the Patient

(a) *To do one's best* for him avoiding all intentional harm. The hippocratic dictum *Primum non nocere* still applies.

(b) Not cutting for stone except by those who are craftsmen in the skill in its larger sense implies the concept of specialisation.

*This clause includes a notion of referral* to relevant colleagues if the illness is not within one's own compass.

(c) *No poison* for homicide still applies. More succinctly, we cannot kill anybody or help anybody in doing so. Euthanasia not sanctioned except in the Netherlands<sup>12</sup> but a debate has started in the context of human considerations<sup>12-32</sup>.

(d) *No abortion* to get rid of an unwanted child. Still applicable though not in all societies. It is certainly taboo in our society except on therapeutic grounds.

(e) *No bodily or more explicitly, no sexual advantage* can be permitted to be taken of the patient or anyone connected with him or her. Our own laws in this matter are very severe indeed.

(f) *Doctor-patient confidentiality* still strongly applies though subject to legal exceptions. It needs to be widely known that Pakistan owes its birth to the strict principle of tight-lipped confidentiality of Quaid-i-Azam's Parsi physician, Dr. Jal Patel of Bombay<sup>8,33</sup>.

(g) *Obligations to colleagues* largely still apply.

## SUBSEQUENT CHANGES

The Oath was adapted to conform to the dictates of the early Christian church. The Arabs in their heyday were the first to make the adapted oath a requirement for entering the profession; this was administered by civil power. The Christian version survives in Scottish and many European countries. In spite of it contemporary Europe has produced doctors like Radovan Karadzic and David Owen. Everyone knows what they have been doing in Bosnia.

Before we move on from the Hippocratic Oath it would be prudent to quote from Wilfrid Circus<sup>5</sup>, who reappraised the Hippocratic Oath recently:

"The taking of Oaths no longer plays much part in the ordering of human affairs"

"As a part of the graduation ceremony it is at best a pleasant archaism. Its spirit is still relevant: it re-

minds the young graduands of the professional ideals which have maintained it. *Ars longa vita brevis*".

The oath then is archaic in its outer form but still alive in some of its vitals even though some doctors have apparently got away with mass murder and other abominable crimes. They have clearly jumped the fence and are not to be considered as part of us.

This much discussion should substantially clarify the present status of the Hippocratic Oath. However, the reality has not driven itself home into the minds of many of us. This is certainly so amongst the laity<sup>34</sup> whose members, including some high ups do fling it in our face now and then. All the same, it must be said that some of the substance of the Oath still occupies a place on a very high pedestal even though it is not reachable in today's medical practice. By no stretch of imagination is it to be viewed with contempt because

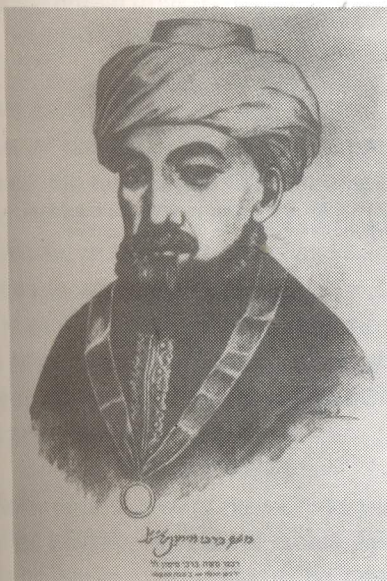


Figure 1:

Moses Maimonides [1135-1204]. (Reproduced by courtesy of the Wellcome Institute Library, London, through the good offices of Dr. Raza Zaidi of Wellcome Pakistan.

of its unreachability (sour grapes!) in our times even by the most sanctimonious among us since '*a profession contemptuous of its own history runs grave dangers*'. --- Sir Henry Cohen (Later Lord Cohen of Birkenhead).

### WHAT OF THE PRESENT

It would be appropriate to consider the current state of medical ethics at two levels, the ideological, if

we still believe in it and we do, though not all can reach these heights, and the practical, mundane level below which our standards should not fall in any case.

First, **the idealistic level:** This was epitomised by Cassel<sup>35</sup> in her ten points that distinguish a learned profession from others. I will quote them as they were quoted by the editor of the JAMA, George Lundberg<sup>36</sup> in 1990:

*"Self governance individually and as a group; service to the poor without expectation of compensation; deliverance of quality; altruism with a certain threadbare nobility; self-sacrifice; heroism as needed and ethical practice with public accountability.*

Some of these standards also are unfeasible for Private Medicine in our milieu where poverty is dominant on the economic scene as against America, where it is not, in the overall picture. Nevertheless they should be kept before our minds' eye for constant motivation and frequent invocation of the famous prayer of Maimonides:

*"Endow me the strength of heart and mind so that both may be ready to serve the rich and poor, good and wicked, friend and enemy and may I never see in the patient anything else but a fellow creature in pain".*

Maimonides (Musa bin Mamoon, 1135-1204AD<sup>39</sup>) was a rabi and the greatest of the Jewish philosophers who was Physician to King Salahuddin Ayubi (Saladin). Such was his ability, integrity and trustworthiness that Richard the Lion Heart also desired him in the same capacity for himself.

The position of the profession today, however, is very different: Lundberg<sup>36</sup> pictures present day medical ethics as a rocking horse shaped like a Gaussian Curve which has an arc like rocking base instead of the straight line  $x$ . When the horse is in normal position (upright) it has an equal admixture of professional and business attitudes and at its extreme ends a small but noticeable segment of money grubbers as an exaggeration of the business segment and a similar noticeable segment of altruistic missionaries at the extreme end of the professional side. The present position of the profession is seen by Lundberg as

### MEDICINE'S ROCKING HORSE

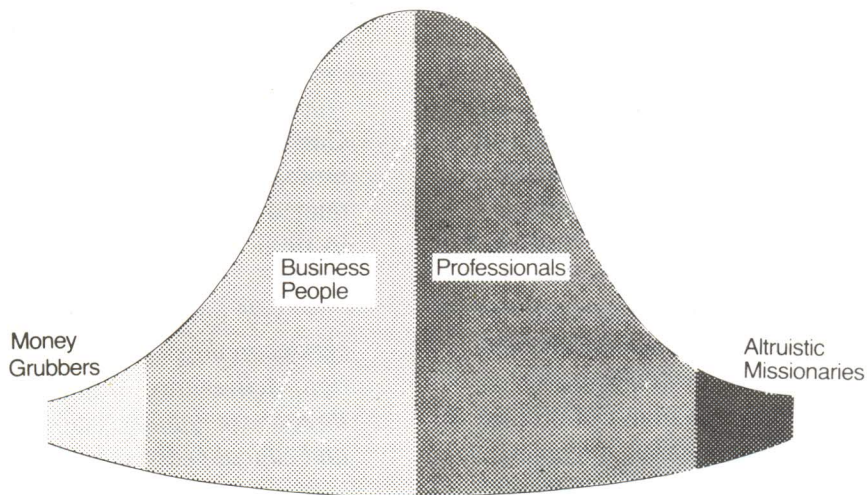


Fig 1.—The natural tensions that are always there between the business and professional ethics of physicians. (Artwork provided by Boon Ai Tan.)

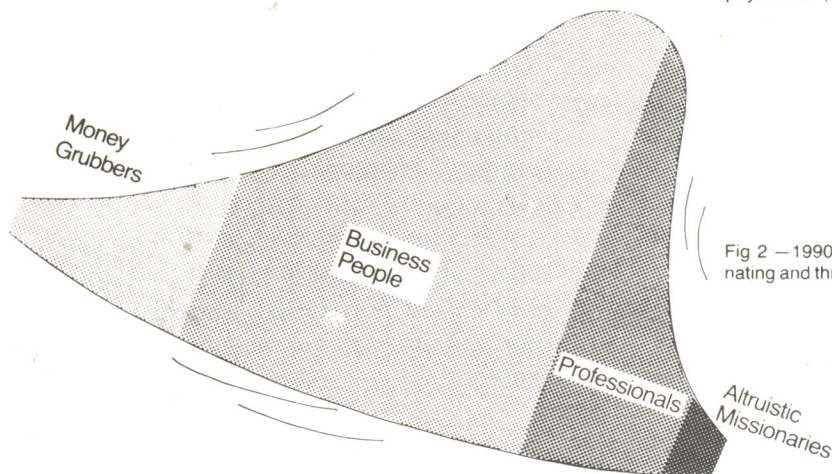


Fig 2 — 1990. The business approach is predominating and threatens to tip the profession over.

Fig 3.—The next millennium. Let's rescue our learned profession.



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tilted and unbalanced so that business people and the money grubbers preponderate, leaving little room for the professional and altruistic people. He wishes that in the next millennium we tilt to the opposite side so that the present pattern reverses in favour of the professionals and altruistic people.

Now let us paraphrase it a little more at the practical, middle-of-the-road level; for the more preachy we are the more hollow we are, a picture we are too familiar with at the national level. Overstating our goals or making them unattainable has a negative effect: it would be enlightening to focus our attention to the fact that some of our best young men and women are opting out of the profession by veering round and competing in the Civil services soon after qualifying M.B., B.S. They form a good 30 per cent of the selectees. This is unprecedented and very bizarre. We should refrain from frightening these young people away from our midst.

We have perforce to see medical ethics in the context of national ethics, not as preached but as practised. No man is an island in a sea of pollution; indeed our profession is in such a milieu. Nevertheless we have to keep our heads and hands above this pollution to attract respect and seek salvation. We have to show out as a learned profession. Professionalism however is easier to recognise than to define. There is a great need for studying ethics and obviously not for doctors alone.

Some of us feel very passionate and enthusiastic about the teaching of medical ethics. While of course this is understandable, it has to be remembered that *precept without practice is a barren undertaking*, devoid of any value, like the pervasive insincerity and malpractices we are familiar with in respect of religion particularly its politicised versions. *Quietly practising role models are the need of our times* and we cannot produce them overnight, without fear of God and the Day of Judgement, however elaborate the pontifications from the pulpit.

Having gone thus far, we could now venture into some undisputable baseline requirements with particular reference to what we see around us. I have written a little more about this earlier elsewhere<sup>37</sup>.

## 1. The Means We Employ to Attract Patients should be Clean

(a) *Sober, appropriate-sized nam' plate*. Not large hoarding, neon light and so on.

(b) *Only genuine and meaningful qualifications be written*. We in the Indo-Pakistan subcontinent are a letter addicted people. It is a matter of style within the limits of legitimacy which, however, cannot be crossed and so we cannot write what we do not possess. M.D. (USA), M.D. (Germany) or M.D. (England) have no validity unless these have been earned from a university. If anything is written after the degree, it is the name of the university rather than the country which is mentioned since countries do not award these degrees and by and large they are fake. Incidentally the M.D. of American Universities is a basic qualification, not a post graduate degree.

Some of the learned societies we join specifically direct us not to add their memberships or fellowships to our names as additional qualifications. We must avoid doing that.

It may also be said in passing that just as it looks ludicrous for some one to write FA, BA, MA, after his name, the same applies to those who write LRCP, MRCP, FRCP unless the qualifications have been obtained from different Colleges or in different subjects. The laity, not doctors, are inappropriately impressed and liable to be deceived. Our profession should have nothing to do with deceit. This requirement should include *administrative medicine*.

2. **Gentlemanliness in all dealings:** The patient is our most important person and all our professional activity revolves around him. We have to do our best for him and should take his hand in our benign and benevolent grasp and possibly keep him in control if he is not competent. Here we have to take care that this control does not turn into a malignant vice. The salient points of this relationship have already been dealt with.

3. **A good doctor-patient relationship:** Depends substantially on the time the two spend together. The

doctor has to show sympathy, preferably empathy. Time is required in taking a proper history, a careful physical examination followed by requisite investigations as necessary and finally, treatment. Even if a patient presents with a spot diagnosis, he would benefit with a little time given to him. If rapid turnover is the primary aim, the doctor-patient relationship suffers directly in proportion to the hurry in which patients are dealt with. This aspect of the doctor-patient relationship has to be sacrificed substantially in the free hospitals where there is no getting away from a high turnover requirement. Subject, of course to deliverance of quality as best as possible.

**4. Professional competence:** This is an area in which most of us to a greater or lesser degree find ourselves on slippery ground if we continuously and conscientiously assess ourselves. Maintaining competence is an ethical responsibility which has to be discharged with all means within our reach<sup>5,6</sup>. Where a problem is beyond an individual's competence, a referral should be made or a consultation had with a suitable colleague as necessary. If a patient desires another consultation, this should not be denied to him. As to philosophical and practical guidance in our day to day practice of medicine there is no better inspiration than the famous prayer of Sir Robert Hutchison:<sup>38</sup>

*"From inability to let alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, and science before art and cleverness before common sense; from treating patients as cases; and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us"*.

**5. Professional integrity and devotion to duty:** Succinctly put, no false medical certificates should ever be issued, even under pressure. If in Government or other employment, the hours of work must be observed. If in teaching appointments, full teaching and clinical duties must be undertaken and there should be neither private practice during office hours nor disappearance from the geographical area of duty in pursuit of private practice. I can do no better than quote the late Colonel Jلال M. Shah<sup>40</sup>, formerly Deputy Director General, Health. Government of Pakistan who told me of his teacher Lord Horder, Physician to the British King Emperor who once received a Royal

Command to come and see the King at once while he was in the middle of his class. He respectfully delayed compliance saying he would be with His Majesty as soon as his Public Duties were over. Here the utter devotion to Public Duties by Horder who was Honorary Physician to St. Bartholomew's Hospital in London was as praiseworthy as the gracious demeanor of the Monarch in accepting the position. This could, of course, only happen in an advanced society but medical teachers in Pakistan can certainly stick to their duty hours unless they wish to invite stoppage of their private practice which is frequently demanded by all and sundry, including periodically, the Government itself. Urgent official calls should of course be complied with, though an attempt should always be made to exhort serious patients to come to hospital which is more appropriate and the right of private practice should not include massive entrepreneur activities like building and running private hospitals during service, for such enterprises with massive capital outlay and patient and hotel like responsibility can exert strong pressure for not putting in one's full effort in the performance of one's official duty. It is also a bad example for students and junior doctors.

A subject which would not ordinarily find a place but must in an article on medical ethics in Pakistan is the difficulty of our men doctors in examining many adult female patients, and the refusal of women doctors to attend to men's sexual area. I served for 2 years on deputation to a women's medical college where to my horror I found men patients being catheterised by sweepers and not the house staff who were young women. My God! Were we to come to this?

I brought this matter up with them and they said they were girls and so would not do that kind of job in an Islamic Country. I have said earlier that maintaining professional competence is an ethical responsibility since without it we cannot do our best for our patients. So also sexual bias should not be allowed to come in the way of serving our patients effectively. The only precaution for women doctors to take is to have a nurse or the patient's wife to be present. I took the next batch of house staff only on condition they would look after my men patients appropriately which they did thereafter without ado.

Contrariwise, the woman patient should have the

nurse or her husband, sister or mother to be present during examination. We have had little difficulty with general ward patients and the upper class; most difficulty is likely to be encountered in the conservative, half educated middle class.

I used to tell medical students to feel as though they were neutral gender while at professional work and be their usual selves again while off work. This would fortify them against feelings of personal embarrassment in attending to the opposite sex and indeed it does work well. If the doctor does not show embarrassment he is more likely to elicit a rational unembarrassed attitude in his patient. This ensures that no patients would be deprived of requisite attention on grounds of sex considerations. I have never found educated and enlightened religious people in the way of my professional work.

Some decades ago Dr. (later Professor) Roy Bhenke of the University of Indiana came to the Jinnah Postgraduate Medical Centre and demonstrated the technique of angiocardiology to us among other things. He stayed for three months in Karachi and on his return wrote a nasty article about being unable to see women patients, and examine their chest and cardiovascular system properly in Pakistan. He thought that it was the menfolk of Pakistan who were depriving half the population of their country from receiving proper medical treatment and thus evading their normal responsibility! I have myself seen some women hesitate being examined properly and in particular allow a proper E.C.G. being done by visual location of chest electrodes. To my astonishment some of them had their E.C.G.s done earlier by some cardiologists whose technicians or they themselves had let it suffice to place the chest electrodes under their shirts and even below their brassiers i.e., in lower intercostal spaces without looking at what they were doing! I call this a slipshod and perfunctory way of doing things by choosing the path of least resistance. On explanation of the proper technique to the husband/mother/sister, it is possible to do it properly in their presence.

We have a woeful lack of pathological post-mortems due to religious and sentimental objections. The profession has to work on this matter thoughtfully and get over the barriers of so called religious

bias. We have to explain the rationale of this procedure and also that our religion does not obstruct advancement of knowledge and proper patient care. Any mistakes discovered post-mortem can help avoiding them in other patients and so promote medical science and community health which is our constant aim. Nonetheless, this matter remains intractable apparently because of unsurmountable emotional constraints and has not thus far lent itself to a solution. I had suggested to the late General W.A. Burki, Minister of Health during the Ayub martial law to make a rule that all patients dying in Government hospitals would be post-mortemed for the common good. He thoughtfully remained silent although it is established normal practice in our Defence Forces.

#### 6. Intra - Professional Relationships:

(a) The future progress of our profession depends upon how seniors treat and bring up our younger highly qualified and trained professionals and how the latter treat the former. The bottom line is: *Do unto others what you would like to be done by.*

(b) *Brotherly behaviour* was enjoined by Hippocrates. It is certainly virtuous always to keep it in mind. Declarations emanating from the World Medical Association however, exhort exposure of incompetent, errant and negligent colleagues. The British Health Secretary has lately wanted this requirement to be a part of the contract of the National Health Service doctors. This clearly is a departure from the Hippocratic approach and would need the utmost care in its implementation. If we keep the patient's welfare foremost in our thoughts, and, any professional vendettas or favouritism strictly out of them, the correct course would present itself to us.

(c) *Rendering professional services to colleagues* this should to be done free as far as possible, as was done by the 'old world' doctors, but there is no ethical bar to charging colleagues if the financial pressures are high. It is no longer considered the right of a doctor to be treated free by his colleagues, although it should normally be a pleasure to do so, particularly when there are frequent professional dealings involved. A special reduced 'courtesy fee' could be considered for colleagues. This should not unduly stress the provider and yet

show special consideration for co-professionals and their dependents.

(d) *Referrals* provide an occasion to display sound professional conduct which is often lacking in our practice. Full protocol requires eschewing avoidable criticism, writing a report back to the referring doctor with advice. No initiative should be taken to change treatment if the matter is not urgent and no attempt should be made to poach the patient. If the matter is urgent, in the interest of the patient the treatment can be immediately changed. If admission or urgent technology/intervention is involved, the necessary steps must be taken under intimation to the referring doctor.

(e) We need to *cultivate humility* in discussions and in dealing with one another. Bombast is repulsive. It only impresses the less critical and the credulous among us.

(f) The profession is being vitiated by the use of *paid agents* whom some of us use for getting work. Practice poaching is common. Fee splitting between doctors would be classed as commercial rather than professional behaviour.

(g) *Unseemly advertising* is going on these days with pictures of doctors appearing in the lay press. This was and is strictly prohibited. There is a burgeoning medical press chiefly consisting of medical newspapers which gives news and views and which is showing evidence of symbiosis between itself and some doctors and also between some doctors and pharmaceutical companies. This needs to be watched and appraised. I would wish that our newspapers showed requisite professional detachment and more evidence of investigative journalism than just alignments whatever the considerations. Medical newspapers edited by lay non-medical people and formal journals edited by learned professionals can not be equated in the field of continuing medical education and non-medical journalists cannot lay claim to educate the medical profession. They can inform and give their views but they can not educate professional people except in matters of style, if their own English is good.

7. **Personal Hygiene:** Must be meticulously maintained. We do smell odours from our patients which can aid in diagnosis but we should not be malodorous ourselves. Dental surgeons in particular need to wash their hands after examining each patient.

8. **Fees:** The independent profession is privileged to charge its own fees which, however, should be as easy as possible for those who can not pay them. They have perforce to be such however, as to be enough to meet one's professional expenses and have a decent though not lavish standard of living.

Razi is known to have charged high fees but he was very altruistic. He impoverished himself by helping the poor and died a poor man. Both these attributes are noteworthy in this great man, but obviously he did not have the practical mix of profession and altruism<sup>2,40</sup>.

Poor people should of course be seen free. Most doctors are happy to do this and some would even help them financially. Provided the better off patients pay them well enough to enable them to do this.

When one sees that no one calls for cheap and "affordable" food, clothing, shelter, sanitation and transport for the poor, which would protect them from starvation and disease in the first place, the usually vociferous demand for free medical treatment to the poor sounds weird and awry. It signifies nothing but an unwillingness of the society/governments in Third World Countries to discharge their responsibility in this area which they like to shift to the private medical profession—a horrific example of passing the buck! The British Medical Profession from which we have learnt so much has been forced to have the BMA registered as a Labour Union, owing obviously to financial and organisational pressures to make for effective bargaining. Be it noted that Health is the heaviest charge on the British Government. A.J. Cronin in his book *The Citadel* and G.B. Shaw paint the medical profession very unfavourably. Was it not Shaw who at one place has written that it pays a doctor more to cut off a man's leg than to dress his wound! This of course is riotous cynicism, but the point to note is that it has been written by those who count.



9. **Our relationship with the Pharmaceutical industry** needs to be pondered and substantially changed.

10. Thus far we have dealt with some fairly straightforward ethical matters. A more academic and analytical discussion would reveal different nuances of such commonly used words as compassion, empathy and sympathy which are common currency in medical ethics. Time and space has not allowed such an intellectual exercise which too is necessary to clarify our ideas on basic issues<sup>41</sup>. Be that as it may, **complex ethical difficulties are getting intertwined with scientific progress**, e.g., new definitions of the beginning and end of life, some aspects of genetic engineering, foetal experiments, organ transplantation and even computer and video records of patients. So the subject of medical ethics has become complex and come into its own as a discipline. The need to see the wood for the trees has led to the development in America of four principles plus reflective concern about the scope of their application<sup>10,11</sup>. An obvious suggestion, however, is that we should not be presumptuous about delivering distributive justice as it is not in our hands in this Country to deliver. We are not in a position to do that. The politicians are. We have to ponder medical ethics at the individual level, at the intra-professional including interpersonal level and to make circumspect attempts to improve the profession-society interface and profession-government interface guarding all the time the principles of self-governance without which we do not remain a profession. Self preservation demands that we rekindle in ourselves our traditional inner lights.

This rather down-to-earth article which has attempted to cover some aspects of the subject cannot end without observing that medical students of today are doctors of tomorrow. We are often wistful of the heyday of Islamic Civilisation when a place of honour was given to medical studies, a corollary to the high respect given to human life. We need to approach this matter with that laudable end in mind. This means merit, inclusive of aptitude and motivation has to reassert itself over other considerations of a populist or personal nature. The ethic of work and of excellence has to hold its sway if medicine in our country has to earn respect for itself. It is a pity that the profession is

not in a position to assure this in all institutions nor even put some restraints on the sky rocketing cost of medical education in some private medical colleges which not only puts enormous financial stress on the students and their parents but also in the ultimate analysis is going to hurt the poor. High costs must in any case correlate with high standards of education and training.

This contribution is based on lectures delivered in the Karachi Medical and Dental College in December 1994 at the inauguration ceremony of their new campus, in Pakistan Society of Physicians symposium 1995 and again at the Karachi Medical and Dental College at their annual symposium 1995.

N.B. It has also been pledged to the Daily Press in adapted form.

#### REFERENCES:

1. Dorlands Illustrated Medical Dictionary. 27th International Ed. Philadelphia: Saunders 1988, pp 767, 973.
2. Bender GA. Great Moments in Medicine. Detroit: Northwood Institute Press, 1968. pp 66-74.
3. Guthrie D. A History of Medicine. London: Thomas Nelson and Sons, 1945.
4. Loudon I. The Hippocratic Oath (letter). Br. Med. J 309:414, 1994.
5. Sircus N. The Hippocratic Oath (Ed). Proc. R. Coll. Physicians. 20:113-115, 1990.
6. Dudley HAF. The Hippocratic Oath Reappraised. Contemporary Viewpoints. No. 1 Professionalism. *ibid*; 21: 188-193, 1991.
7. Kilpatrick R. The Hippocratic Oath Reappraised. Contemporary Viewpoints. No. 2. Integrity. *ibid*; 21:328-331, 1991.
8. Smith AM. The Hippocratic Oath Reappraised. Contemporary Viewpoints. No. 3. Confidentiality: limits to the Public Interest in its breach. *ibid*; 21: 444-7, 1991.
9. Carlisle A. The Hippocratic Oath Reappraised. No. 4. Hippocrates and the Consumer. *ibid*; 22: 206-10, 1992.
10. Beauchamp TL and Childress JF. Principles of Biomedical Ethics. 3rd. Ed 1989. New York: OUP. quoted by Gillon R.
11. Gillon R. Medical Ethics. Four Principles plus attention to Scope. *BMJ*; 309: 184-8, 1994.
12. Van der Wal G, Dillman RJM. Euthanasia in the Netherlands. *BMJ*; 308: 1346-9, 1994.
13. Ward BJ, Tate PA. Attitudes among NHS doctors to requests for euthanasia (letter). *BMJ*; 308, 1332-4, 1994.

14. Ferguson A. Ethics and Euthanasia. Opinion Polls not decisive (letter). *BMJ*; 308: 1570, 1994.
15. Catterral RA. Ethics and Euthanasia. Legislation will not solve problem (letter). *BMJ*; 308: 1570-1, 1994.
16. Heintz APM. Euthanasia can be part of good terminal care. *BMJ*; 308: 1656, 1994.
17. Smith AM. Euthanasia. Present law protects doctors and patients (letter). *BMJ*; 309: 471, 1994.
18. Twycross R. Euthanasia: Acquiescence corrupts Dutch doctors (letter). *BMJ*; 309: 471-472, 1994.
19. Madeley P. Euthanasia: Role of depression ignored (letter). *BMJ*; 309: 472, 1994.
20. Gilbert J. Euthanasia: Prediction of Outcome can be wrong (letter). *BMJ*; 309: 472, 1994.
21. Ventafriida V. Euthanasia: More palliative care is needed (letter). *BMJ*; 309: 472, 1994.
22. Thomson HJ. Euthanasia: Stay away from the slippery slope (letter). *BMJ*; 309: 473, 1994.
23. Fergusson A. Euthanasia: Natural and unnatural death (letter). *BMJ*; 309: 473, 1994.
24. Saunders PJ. Euthanasia: Undermines patient autonomy (letter). *BMJ*; 309: 473, 1994.
25. Finlay IG. Euthanasia: Do not change existing law (letter). *BMJ*; 309: 473, 1994.
26. Ward B., Tate P. Euthanasia: Author's reply (letter). *BMJ*; 309: 473, 1994.
27. Rodway A. Euthanasia: Precise definitions are needed (letter). *BMJ*; 309: 52, 1994.
28. Collins K, Gilhooly MLM, Keith M. Euthanasia: Attitudes are influenced by age and religion (letter). *BMJ*; 309: 52, 1994.
29. Twycross R. Euthanasia: Don't follow the Dutch (letter). *BMJ*; 309: 52, 1994.
30. Helme T. Euthanasia: Opinion polls are helpful (letter). *BMJ*; 309: 52-53, 1994.
31. Davis A. Euthanasia: Permanently disabled people may have curable depression (letter). *BMJ*; 309: 53, 1994.
32. Ogilvie AD, Potts SG. Assisted suicide for depression: the slippery slope in action? *BMJ*; 309: 492-3, 1994.
33. Collins, L, Lapierre D. Freedom at midnight. New York: 1975, Simon and Schuster, p. 164.
34. Lahori. The Hippocratic Oath you said? Dawn, Karachi, May 18; p. 2, 1990.
35. Cassel, Christine K (1989). Oral Communication cited by Lundberg G. (Ed) *JAMA*; 263: 86-7, 1990.
36. Lundberg G. Countdown to millennium - Balancing the professionalism with the Business of medicine. *Medicine's Rocking Horse* (Ed) *ibid*.
37. Hasan M. All points made by Lundberg are valid for Pakistan as well even though I fondly hope they apply with less force (Ed. Comments from Pakistan). *JAMA Pak*, 2: 334-7, 1990.
38. Hutchison R. Cited by Tierney LMJr., McPhee SJ, Papadakis MA (Ed). *Current Medical Diagnosis and Treatment 1995 Connecticut: Prentice Hall International*, opp. p. 1.
39. Margotta R. *An Illustrated History of Medicine 1967*. English Translation Ed. Lewis P. 1988. Feltham, Middlesex, The Hamlyn Publishing Grp pp 109, 116.
40. Shah JM. Personal Communication (1970).
41. Charland LC, Dick PT. Should compassion be included in codes of ethics for Physicians? *Annals Roy. Coll Phys & Surg Canada* 28: 415-18, 1995.