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EDITORIAL

FROM THE HIPPOCRATIC OATH TO DECLARATION OF GENEVA (2017) (PHYSICIAN'S PLEDGE)

The Hippocratic Oath is associated with the practice of medicine, but over time fewer medical graduates have taken any form of the Hippocratic Oath. As the contemporary successor to the 2500-year-old Hippocratic Oath, the Declaration of Geneva, which was adopted by the World Medical Association (WMA) at its second General Assembly in 1948, outlines in concise terms the professional duties of physicians and affirms the ethical principles of the global medical profession. The Hippocratic Oath has been revised to make it more acceptable to modern schools. This editorial will look at the classic version of the Hippocratic Oath to see why it has been abandoned. The Hippocratic Oath has four parts: a pledge to deities, a list of positive obligations, a list of negative obligations, and a concluding piety.

1. PLEDGE TO DEITIES: A pledge to a deity is the basis of a solemn promise. Ancient ethical systems were based on Divine-Command Theory. The distinction between right and wrong was derived from commands by a deity. A pledge to a deity is equivalent to a pledge to act morally right. Modern ethical systems are duty driven in nature. Ethics have been based on reason from basic axioms of duty rather than from divine commands.

2. POSITIVE OBLIGATIONS: The distinction between positive and negative obligations is essential to understanding ethics. A positive obligation is something that one is REQUIRED to do. A negative obligation is something that one is FORBIDDEN from doing. The Hippocratic Oath includes both types of obligations.

a) Honor Thy Teacher

… To hold him who has taught me this art as equal to my parents and to live my life in partnership with him …This portion of the Hippocratic Oath is a relic of the Master/Apprentice Model of training. Both the master (teacher) and apprentice (student) had obligations to each other. There was an implicit contract between them. The apprentice would learn from the master until the master graduated the apprentice with a letter of recommendation. This system has been replaced by University system or Pvt. Colleges where relations have become contractual.

b) Professional Courtesy

… if he is in need of money to give him a share of mine, …No physician would charge for services rendered to another physician or medical student, or to any family members of such. Today Private hospitals will protest that Professional Courtesy would be a violation of Stark Laws that view preferential treatment to colleagues as a form of kickback.

c) Guild Secrets

*.. and to regard his offspring as equal to my brothers in male lineage and to teach them this art — if they desire to learn it — without fee and covenant. P*revious versions called for students to respect their teachers, but now have deviated from the Hippocratic Oath, which calls for mutual respect between teachers and students. "I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due".

d) Work to Aid Patients

*... I will apply dietetic measures for the benefit of the sick according to my ability and judgment; …*Note in this passage the term, "according to my ability and judgment" which acknowledges that fulfillment may not always be possible. Many physicians would agree that their duty is to their patients. In an ideal world, physicians would place the interest of their patients above their own interests or the interest of the hospital.

e) Non-maleficence

... I will keep them from harm and injustice. Primum non nocere is the Latin phrase that translates "First do no harm". The physician must ... have two special objects in view with regard to disease, namely, to do good or to do no harm. Modern medical ethics consider four deontological principles: autonomy, justice, non-maleficence, and beneficence. Ethical advisors, recommend: "I WILL RESPECT the autonomy and dignity of my patient." "I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice." Now systems of ethics are based on the Utilitarian Principle of the greatest good for the greatest number.

f) Fidelity to Principle

... In purity and holiness I will guard my life and my art.. It pledges to be true to the Oath regardless of consequences. Recently adopted Statement on Physician Well-Being is. "I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard."

g) Confidentiality

... What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about. In the ancient era confidentiality between physician and patient was absolute but the modern physician has subordinated doctor-patient confidentiality to public safety.

3. NEGATIVE OBLIGATIONS

a) Euthanasia

... I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. This is a negative obligation

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forbidding the practice of euthanasia. The modern medical era has seen a shift in attitude more favorable to euthanasia. This negative obligation has been dropped from some of the modern versions of the Oath. Supreme Court of India has approved passive euthanasia in March 2018.

b) Abortion

... Similarly I will not give to a woman an abortive remedy. Abortion has seen a much larger shift to which a segment of medical practice is dedicated to abortion. Abortion is the most polarizing issue of modern time.

c) Protecting Guild Turf

... I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work. Here is another negative obligation which prohibits physicians from acting as surgeons. Internists have descended from the ancient order of physicians. Surgeons have descended from the ancient order of barbers. There is now considerable overlap between the practices of internists and surgeons and both groups consider themselves to be physicians.

d) Sexual Relations with Patients

... Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves. The negative obligation forbidding sexual relations between physician and patient is one that remains in full force in the modern era. Most professions consider this boundary to be absolute. It now includes the teacher-student relationship also.

4. CONCLUDING PIETY

... If I fulfill this path and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot. This is a common literary device for a pledge.

Ancient physicians were granted monopoly privileges by the government to practice their craft and police their ranks. In exchange, physicians agreed to live by a code of ethics as delineated by the Hippocratic Oath. One of the few parts of the classical Hippocratic Oath that remains accepted in the modern era is the promise to put the interests of the patient above all interests. In today's era, patient is the **'King'** and **'Consumer'** and participates in decision making. Meaning and implications of Hippocratic Oath have changed. Re revised Declaration of Geneva may see many more revisions in times to come.

Dr. A. K. Dewan
Director - Surgical Oncology

CME – DHAKA, BANGLADESH

RGCIRC organized two day's CME with Square Hospital Limited and Urologists Association on 7th to 8th March 2018 at Square Hospital Limited, Dhaka, Bangladesh. On first day, Dr. Sudhir Kumar Rawal, Medical Director and Chief of Uro - Gynae Surgical Oncology delivered a lecture on "Robotic Radical Cystectomy – Technique & Results", Dr. Rupinder Sekhon, Sr. Consultant & Chief of Gynae Surgical Oncology spoke on "Robotic Radical Hysterectomy – A Clear Cut Advantage in Ca Cervix & Ca Endometrium and Robotic VEIL in Carcinoma Vulva", Dr. Rajeev Kumar, Sr. Consultant - Surgical Oncology spoke on "Breast Preservation and Reconstruction in Today's Time at Tertiary Cancer".

On second day, Dr. Sudhir Kumar Rawal, delivered lectures at Urology & Transplantation Foundation of Bangladesh (UTFB) on two topics "Robotic NSS – Standard of Care Even in Complex Tumors" and "Open Radical Cystectomy (Mini Lap) – How to Improve Results?" and Dr. Rupinder Sekhon spoke on "Robotic Radical Hysterectomy – A Clear Cut Advantage in Ca Cervix and Ca Endometrial" in the said CME. CME was organized with the help of Dr. Ninan Chacko former HOD of Urology, CMC, Vellore and now heading UrologyDepartment of Square Hospital, Dr. M. A. Salam, Chairman, UTFB and renowned in Uro – Oncology in Bangladesh. CME was attended by one 100 doctors.

CME – IMA OUTER WEST BRANCH

RGCIRC organized a CME in association with IMA Outer West Branch on Saturday, 10th March 2018 at Hotel Radisson Blu, Paschim Vihar, Delhi. Dr. Mudit Agarwal, Sr. Consultant – Head & Neck Surgical Oncology delivered a lecture on "Recent Advances in Head & Neck Surgery" and Dr. Ullas Batra, Sr. Consultant and Chief of Thoracic Medical Oncology spoke on "Approach to Lung Cancer" in the said CME.

IMPACT OF CHILDHOOD CANCER ON THE FAMILY: ROLE OF COUNSELING AND FAMILY EDUCATION

According to the Globocan 2012 and ICMR registry data, it is estimated that each year in India there are approximately 50,000 children between the ages of birth and 15 years of age who are diagnosed with cancer. Globally there are more than 300,000 children diagnosed with cancer annually. Getting the news that your child has cancer can bring with its diagnosis an extraordinary emotional toll, which cannot be calculated.

With modern treatments, childhood cancer is curable in nearly 80% of cases. However, its diagnosis has a devastating effect on the family because of its potentially life threatening nature requiring major shifts in lifestyle and psychological reality. It is a significant stressor that can affect the psychosocial well being of family members and their interactions with one another from diagnosis to survivorship and/or end of life care. Many families adjust well after the initial disruption following diagnosis and initiation of treatment. However, there is often an increased risk for parental distress, particularly among mothers.

Parents involved in the care of their child with cancer, often experience both positive and negative emotions such as anxiety, guilt, anger, and distress during the course of the child's illness. These emotions are usually felt and variably expressed by all family members. The child's cancer affects the family's need for care, self-esteem, social interaction, and functioning. Consequently, parents may find it necessary to change or modify their family roles to cope with the demands of their child's illness.

Supportive care of the family therefore needs to be multidisciplinary and evidence based to address information needs, decision making, adjustment, and long-term challenges into survivorship or after a child's death. The child and the family are required to develop new coping skills, make use of outside support and resources, and receive specific interventions in order to maximize their adjustment. Continuing improvements in outcomes of cancer therapy and in psychotherapeutic treatment will reduce the psychological impact and assist in the child and family's adjustment to childhood cancer.

Our unit has a dedicated after completion of therapy clinic to take care of health for all those who have successfully completed the treatment. It aims at screening for late effects and emphasizes importance of healthy life style.

Assessment

Family members of cancer patients are at great risk of experiencing psychological distress. However, clinical tools to assist with recognizing and intervening with appropriate psychosocial care are sparse. The family is required to adapt to many situations like long hospitalizations, aggressive therapy leading to changes in family relationships and routines. Challenges for the caregivers include fear of relapse, anxiety, and need to adapt to the new health condition. These, among other situations, may negatively impact the family's quality of life.

The child or adolescent undergoing treatment needs to deal with invasive procedures, side effects, the interruption of school and social routines, the suspension of leisure activities, changes in diet, self-image and self-conception, uncertainty of how the treatment will progress, doubts, periodical hospitalization, physical pain, separation from family members and familiar places, losses that harm socialization and interfere in personal relationships.Considering the context to which the patient's parents are exposed, it is important to identify the psychosocial impact imposed on caregivers in order to understand their experiences and devise efficient psychosocial interventions.

Tools for assessing psychological distress are sparse. Both the parents and patients are assessed through case history, interviews, questionnaires and psychological tests (for depression or anxiety) at different phases of the treatment as and when the need arises. In our department at RGCIRC we have initiated the use of The Distress Thermometer, a tool to quantify this issue. It also helps the team & family members to begin a conversation with each other about the wider range of difficulties such as psychological, spiritual, social and practical problems, together with the services and resources that may be helpful in addressing them.

Table 1: Resources for the Family - In The Department of Pediatric Hematology Oncology

Resources	Impact
1. Counseling of family members / Family counseling	•Reassurance, support and encouragement •Help the family find more effective ways of coping with day to day issues •Identifying options leading to an improved quality of life
2. Group counseling	•Develop coping skills •Help patient and caregivers deal with their feelings, hopes and fears
3. Parent Support Group Meetings	•To help adjust to the new reality •Reduce stress, and improve ability to deal with stressors •Specifically, parents gain increased skills, an increased sense of power and a sense of belonging •Reduces the feeling of isolation and loneliness
4. Meditation sessions for families and caregivers 5. Positive mindfulness counseling	•Reduces parental stress and results in parental reactivity through catharsis •Helps control anxiety •Promotes emotional health and enhances self awareness •Acceptance of thoughts and feelings, without judging them
6. Family Education by providing information booklets and brochures and education sessions with the team	•Providing information to the patients and the family about the treatment, procedures, side effects, other disease related issues, prognosis •By being better informed families cope and adapt faster

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For many reasons, we know that it can be difficult for both the health professionals and the person to discuss the broad range of challenges; therefore the role of counselor is important in discussing about these issues and addressing them appropriately. Distress screening for family members of cancer patients is a promising and efficient approach to integrating family members in the program of care and provides the first step toward meeting their unmet needs with referral for supportive services.

Resources for the Family at RGCIRC

Recognizing the need for psychological interventions in our families, we in the Department of Pediatric Hematology Oncology at Rajiv Gandhi Cancer Institute and Research Centre, provide important resources for them (Table 1). These specific interventions help maximize their ability to adapt.

Along with children, the family members may also experience medical and physical effects, psychological effects, cognitive and neuropsychological effects, all of which can impact their experience of transitioning back into the lives and routines they had prior to diagnosis. Therefore, mental health interventions are vitally important in helping children and their families cope adaptively to ensure positive long-term adjustment.

Family education plays an increasingly important role in healthcare. We cannot change a child's diagnosis, but we can help ensure their journey is one of love and hope, when a family can do so together.

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