

RINCKSIDE

VOLUME 10 • 1999

SCIENCE
MEDICINE
IMAGING
ACADEMIA
PHILOSOPHY
ETHICS
SATIRE
ADVICE

ISSN 2364-3889

RINCKSIDE

ISSN 2364-3889 • VOLUME 10, 1999

CONTENTS

Rinck PA. Quality means back to basics. Rinckside 1999; 10,1	1
Rinck PA. Bigger does not always mean better. Rinckside 1999; 10,2	5
Rinck PA. Some thoughts about contemporary ethics in medicine. Appendix: The Hippocratic Oath and the Declaration of Geneva (1948). Rinckside 1999; 10,3	9
Rinck PA. The front and back of medical journals. Rinckside 1999; 10,4	15

Quality means back to basics

Peter A. Rinck



When you go to a restaurant and find the tables dirty, the service slow and unfriendly, and the food tasteless, you describe the quality of this establishment as low. This kind of assessment is easy and can be done by anybody. In medicine, thus also radiology, the prevailing benchmarks for measuring quality are the opinions of the patient, the referring physicians and, last but not least, your own knowledge whether you perform to the best of your abilities.

Quality assessment becomes more difficult when patient care involves technology that is not transparent to the layman or even to the user. This holds for cars and aircraft, as well as for imaging equipment. So many things can go wrong with modern electronic imaging machines that it is quite amazing that scanners produce images of such high quality.

When people talk about quality assurance, they usually mean preservation of equipment performance. In Europe, there is no set process for a generally accepted quality control in radiology.

Cost and quality are the two most discussed aspects of patient care and getting the balance right is difficult. Everybody would like a decrease in costs and an increase in quality. Usually, however, costs increase, and many people believe that this goes hand-in-hand with an increase in quality; but this assumption is hard to prove.

■ Deterioration of image quality is often a slow process. At the beginning, it goes mostly unnoticed. One then becomes accustomed to the way the images look and begins to believe that they are of good quality. When looking at your patient studies, colleagues realize that the quality of your images is not up to standard or actually poor. Commonly, they put the blame on the manufacturer, not on the owner of the machine. This is right legitimate in many instances because the manufacturer is also in charge of servicing the equipment. Hardly any radiologist who own or are in charge of a machine is able to service it or even reliably test its quality and performance. Even if they knew how, they would not have the time required to maintain its top performance.

This can result in two outcomes: first, poor image quality, which ultimately means poor patient care, and second, negative comments about manufacturers, such as: “The equipment of manufacturer X which you know is eight years old creates better images than a similar machine by manufacturer Y, which is only eighteen months old.” This contrast might be only due to differences in service and maintenance.

Recently, someone told me that his 0.2-Tesla MR machine makes better images than the neighbor’s 1-Tesla machine. The reason was not that the higher-field machine was worse per se, but that the owner had not “wasted money” in consistent service.

There is no doubt that manufacturers make a lot of money from service. Part of this money can be saved by performing daily quality checks and a weekly quality assurance program during the weekend. If the institute or department is large enough, an in-house engineer, physicist, or radiographer trained in quality assurance is a worthwhile investment to insure continuing image quality.

Supervision and affirmation that the nature of your medical service is optimal should never be forgotten. Always keep in mind that the best of your knowledge might not be good enough. Also remember that medicine is not an exact science. The technical aspect is only a part of it.

Quality control and quality assurance are expensive. They require time, money and the admission that you might not be perfect. There is not straight feedback or financial remuneration for quality control. Public recognition will follow, but it might take five or even ten years. With public recognition, the influx of patients will increase, because patients and referring physicians will trust you and your institute.

Plan ahead

Quality assurance and control programs require long-term planning, which can be tedious. People working with you have to accept their necessity and have to stay in the department or private practice for years.

For staff just passing through to is more difficult to understand how quality assurance works. It is a way of life which cannot be picked up in a month or two.

The restaurant example can easily be translated into a familiar scenario: Patient may have a similar experience when visiting a radiologist. Quality is often assessed from the waiting room and the desk of the referring physician, both angles from which you commonly do not watch your work.

The following account is not a single case; you might have heard similar stories. I choose it because it does not involve a radiologist. Appearances can be deceptive, but sometimes they are true.

■ Last winter, a friend of mine felt unwell. She made an appointment with a gynecologist. This gynecologist worked in a very fashionable neighborhood, but did not make a good impression on my friend. His rather small waiting room was crowded and did not have enough chairs. The wall of the waiting room were painted in a dirty-brownish hue. The well-thumbed magazines on the table were old and greasy from the fingers of many patients. Patients need something to distract them, to read, to look at – some easy reading, to get their thoughts off the ordeal which may await them – but here they didn't want to touch the magazines.

The doctor finally appeared more than an hour after the set appointment. He also looked slightly dirty. His hair was too long and had not been washed for some days. He did not introduce himself but grumpily asked for my friend's complaints.

While he listened to her description, he started without further explanation an ultrasound examination which was accompanied by: "Hmhm, hmhm ..."

He then ordered some blood tests and prescribed a medicament against a disease he presumably had found in the ultrasound examination, again without further explanation. When asked the secretary what the diagnosis was, she answered: "What the doctor has told you."

After buying the prescribed drug at the next pharmacy, my friend read its description which listed more side effects than wished for effects. She did not take it because she did not trust the doctor; she had neither faith in the diagnosis nor the treatment proposal and went to another doctor in a different city.

This second doctor was the complete opposite of the first; he, his technicians and his office were neat, and he explained everything he did to her in detail. When he repeated the ultrasound examination he found no pathology.

Admittedly, this story sounds like an invention to hammer home the point, but it is true. Of course, it could also be the other way around: The clean and talkative doctor might not know how to use the ultrasound equipment and how to interpret the images.

Smile, be friendly, try to explain the procedure to patients, and tell them when you expect the results.

Roots of the problem

An ancient Greek physician said something along the lines of: "Quality starts at home". In other words, do not look at others or blame others, blame yourself first.

A friend-foe relationship sometimes develops between physicians (as well as nurses and technicians) and patients. Many hospitals – and departments of radiology – are run in a way that patients are considered a nuisance. This should not be the case but is part of human behavior.

Very few people have enough patience and permanent dedication to their sick, helpless and often querulous counterparts. Everybody has good or bad days. You may not feel well, you are tired, but the patient should not feel this, he will have the impression that your bad mood is connected to him and his disease. This is easier said than done, but quality assurance means self-discipline and includes politeness.

■ Quality means simple things such as not showing a bored face, not receiving patients impolitely, introducing oneself and one's position, and explaining the radiological procedure. This holds true in all countries, for nurses and technicians, and for residents and professors.

You can raise the quality of your radiological examination by numerous simple routines - from placing flowers in the reception area to providing clean gowns for the employees. Smile, be friendly, try to explain the procedure to the patients, tell them when the referring physician will receive the results.

Try to schedule patients in a way that they do not have to wait too long. If a wait is necessary, there should be distractions and patients should be reassured that they have not been forgotten. Try to resolve complaints from patients or from referring colleagues. Encourage them to put complaints in writing. This ensures that notorious trouble-makers among patients, doctors and administrators, and among your own radiological staff are kept at bay. It also allows to follow up problems easier.

Good medical quality also means that the department heads – as well as everybody else – are friendly and open towards the rest of the staff, supporting them and keeping them informed. Duties should be delegated and people made responsible for their tasks, without overloading them with work. This also means that bad apples have to be removed, even if it hurts. Ambitious and content staff working on defining improvements and seeing them through will be the best quality assurance possible. People will easier cooperate with one another and their manager under these circumstances.

Many things can, and often do, go wrong which can seriously degrade image quality – both the radiological image and the image of radiology.

Rinckside, ISSN 2364-3889

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Citation: Rinck PA. Quality means back to basics. Rinckside 1999; 10,1: 1-3.

Bigger does not always mean better

Peter A. Rinck



In the pharmaceutical industry, Hoechst and Rhône-Poulenc Rorer have amalgamated to form Aventis, Ciba and Sandoz have merged to create Novartis.

According to a company statement*, Novartis comes from the Latin term "novae artes", which means "new arts" or "new skills." "Rhône-Poulenc Rorer and Hoechst have adopted the name Aventis for the creation of a new world leader in the Life Sciences", a statement of this newly merged company reads*: "The name evokes the idea of movement, innovation, science, the future and constant progress."

"Perhaps the most frightening aspect of the spate of mergers in healthcare is that it would cause little or no surprise if we were told that *Enuresis* is to become the new global player."

Perhaps the most frightening aspect of the spate of mergers in healthcare is that it would cause little or no surprise if we were told that *Enuresis* is to become the new global player in radiology and the most recently created pharmaceutical megalo-company. *Enuresis* is a corporation that will have a major impact upon the radiological community, according to a company spokesman. The new company combines one of the world's biggest soft drink producers, a company whose products are commonly described as "defense material", and a pharmaceutical firm. The company motto would be "Let's get pissed" **.

Its Latin name would give it an air of seriousness. All radiological departments dealing with *Enuresis* would have to install a soft drink dispenser if they wanted to purchase their contrast agents at a special reduced price. This would be good news, because it would mean decreased expenses in radiology.

Industry has the most resources, the best thinkers, and the greatest insight into the needs of the healthcare system – if industry is to be believed. Its recipe is company mergers and an intensifying drive towards globalization.

What does all this corporate maneuvering mean to radiology?

James F. Smith, professor of finance at the Kenan-Flagler Business School at the University of North Carolina at Chapel Hill in the United States, explains the background of mergers:*

"Last year's deals set a volume record, enriched Wall Street dealmakers ... The gloom and doom crowd has been joined by the editors of the famous magazine, *The Economist* ...

"My wonderful students, the Kenan-Flagler Business School MBA class of 1999 ... handled these ridiculously pessimistic articles with aplomb.

"Thanks to other classes in the first year MBA curriculum, they knew that most mergers today are being driven by technological change and the need to be large enough to compete successfully on a global stage. Most mergers are not driven by the egos of corporate managers, as frequently happened in the past, but rather by market opportunities and the ability to raise productivity dramatically."

"Hear, hear," * as they yell in the British parliament.

Now, let's apply these teachings to mergers in medicine and, particularly, radiology. Let the companies speak for themselves. The spokesman of one company involved summarized one the recent deals as follows:*

"Today's healthcare market is desperately seeking efficiency, and that is what our merger is all about. By adding the other company's nuclear imaging and magnetic resonance capabilities, this acquisition will enable our company to better serve the world's medical caregivers [*I like this word; one positively smells the lie. The author*] and their patients ... Our new bigger company will bring new product and technology synergies to healthcare providers – providing significant productivity advantages for health care providers leading to enhanced patient care."

This is exactly what we need in our radiological departments and practices. The public relations statement of the company involved continues as follows:*

"This transaction is a testament to the talent and dedication of our employees. In the future, the customers of the company we bought will benefit from the breadth and depth of our imaging systems, support and service offerings. Furthermore, the sale enhances the shareholder's value and provides additional resources for the pursuit of future business opportunities."

■ Let's explain some terms:

In this context, "synergy" means that there are two companies producing radiological equipment or accessories. Usually, in the synergistic world, the better one will disappear.

"Consolidation" implies the contrary of competition.

■ For some radiologists this stands for waking up one morning and finding out that they are the unlucky victims of the merger craze – some are even unhappier because they had just acquired machines from a company which has been taken over by another. Parts of the contracts they just signed after long deliberation will not be fulfilled. This is an excellent solution for less unemployment because the lawyers of the radiologists will talk to the lawyers of the global player, which keeps the lawyers off the street. There are few other beneficiaries.

■ What else can happen? A Central-European company was interested in ultrasound and bought a specialist ultrasound manufacturer. The new owners discontinued some of the products, and some medical doctors were stuck with ultrasound equipment that lacked software because the purchaser had fired the software engineers. This is indeed "a testament to the talent and dedication of our employees."

What else is positive for radiologists and medical doctors? Let's listen to the spokesman of two other merging companies*:

"The combination of our preeminent long-term care providers will create an important new force in the industry, with increased growth potential from an already rapidly growing base. The combination of our two companies will enhance our ability to offer superior and innovative patient services at a time when

the long-term care industry is both growing and consolidating."

Permanent economic growth is as likely as the *perpetuum mobile*. Therefore, the spokesman knows what he means when he says: "Both growing and consolidating." Do not believe that this is a satire – this is a public statement of the president of a major healthcare company.

Many of the companies eating or being eaten do not lack solidity, but sometimes the management does. I would rather cooperate with companies whose aim it is to provide good service for me, my department, and my patients. I have nothing against them making money – on the contrary, without profit there is no survival. However, I do not need permanent growth which can only mean replacing equipment and accessories ever faster.

In addition, big company means big administration, and big administration means little responsibility. With a small or medium-sized company, customers usually find the person responsible quite easily without looking for days. Global companies have structures which hamper decision-making for their products and customer services.

Smaller companies products are often more innovative and of better quality than those of the giants. They have a more flexible management that is interested in the companies' and customers' benefit, not only in their own. In general, the bigger the company, the less competition exists, and with size comes bad products and poor customer relations.

The employees never know if they will be fired the next day. This creates a state of anxiety in the sales and service representatives, which you can feel when they visit you. You know that you cannot rely on people like this – although you might feel pity for them. You want a long-term relationship with a supplier which means having the same (and hopefully happy) reference person over a long period of time.

Additionally, the company image suffers and the identity of both employees ("proud to be an IBM employee") and customers ("Siemens equals German quality") may disappear. What is a Crimler (Daimler-Chrysler) or a Volks-Royce (Volkswagen-BMW-Rolls Royce) compared with a Mercedes-Benz or a Rolls Royce? Anyhow, 60% of all mergers do not work out at the end.

Therefore one would rather like to see a semi-big multinational company with national, partly independent production sites, manufacturing radiological products in and for a small region of the world – with a company culture fitting the healthcare system of this region. Healthcare is fundamentally different from most goods and services and is consequently best delivered in a setting where community needs are primary concerns.

■ The press release cited earlier ends with the following statement*:

"This release contains certain forward-looking statements which involve known and unknown risks, uncertainties or other factors not under the Company's control which may cause actual results, performance or achievements of the Company to be materially different from the results, performance or other expectations implied by these forward-looking statements. These factors include, but are not limited to, those detailed in the Company's periodic filings with the Securities and Exchange Commission."

Always read the small-print, as my grandmother used to tell me.

■ **Footnote:** *real statement; **invented statement.

Rinckside, ISSN 2364-3889

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Citation: Rinck PA. Bigger does not always mean better. Rinckside 1999; 10,2: 5-7.

Some thoughts about contemporary ethics in medicine

Peter A. Rinck



There is an increased discussion of ethics in our societies which coincides with a growing controversy of ethics in medicine. For a long time any debate of ethics was considered a reactionary topic in which people with progressive views would not engage — and everybody wanted to appear progressive. This has changed.

Recently even the German news magazine "Der Spiegel" published a special issue entitled "Volk ohne Moral - People without Morality" branding the Germans as immoral and unethical.

■ However, the decline of values is not restricted to the German society. The Swiss and the French, the Italians and the British — Europe at large and the rest of world seem to respect less and less basic virtues necessary for people to live together in a peacefully balanced social order.

This decline of values has also spread into medicine and radiology. The entertainment and consumption culture are slowly taking over public spirit and sense of responsibility. A life-style of arbitrary and random attitudes towards one's own and other people's behavior has developed which euphemistically is described as tolerant and liberal.

The stultification and mental debilitation of the population by television, gutter newspapers, tabloids, combined with poor education, hinder reflection and lead to trivializing tendencies and habit-forming effects which should have been overcome a long time ago according to popular political opinion. In the meantime everybody takes what they want. What seems uncomfortable or what seems not to be interesting is avoided.

The churches as a shrine of moral and ethics — if they ever have been such a shrine — have also lost their importance. When life is good without major problems they always lose their influence. People are sure that, if there are problems, the doctor/lawyer/state will fix them. There is a permanent tenor in some European countries: "The state is responsible."

However, who is the state? A welfare institution we subscribe to? Or an institution we are members of? Hardly anybody seems to remember public moral.

These were its maxims: "Do not do anything to somebody you do not want to happen to you — this is the principle of all virtue and all duties of the human being towards society" (Frederic II of Prussia, describing his ideas of the Prussian state), and "Un prince est le premier serviteur et le premier magistrat de l'Etat" (Frederic II of Prussia: Œuvres. 1, 123; 1751).

The ethics of western medicine have their origin in the Hippocratic oath, a code of conduct which has guided the practice of medicine for more than two millennia (see Appendix). How do these guidelines fit into our medical environment which has more or less become value-neutral? Most of the factors applicable for medicine in general also apply for radiology. In the welfare states some of them differ from countries with a pure capitalist health system.

Honor your teacher ...

Hippocrates begins his oath talking about the bond between mentor and disciple in medicine. This touches human relations between, for instance, radiologists. Who is aware of any account of teachers in radiology complaining about young colleagues not being thankful for what they have learned — that is, if they were good teachers?

... if your teacher respects you.

On the other hand, it is no secret (but a taboo topic) that life in radiological departments can be hell. Bullying is common and, in some countries, believed part of life during the training and education of young radiologists.

Some heads run their departments like small feudal states and spread terror and exploit their employees. Incredible stories about the treatment of young radiologists by their superiors are legion.

■ There is the recent story of two radiology residents who could not stand the terror of their boss any more. They quit their job. Not only were they told by their boss that their scientific results of the last years were his to keep. He would also see to it that they would never again get a position at a university or at a hospital department in that country. The boss' wife told her children not to play with the children of one of the radiologists in the kindergarten and did not greet or even notice any more the wife of the other one when meeting her in the supermarket.

One can hear such stories over and over again. Usually young radiologists do not dare to quit their job and speak up. Often they are psychologically broken and left with a deformed character. To be at someone's mercy is terrible; fortunately, most leaders of radiological departments are people of rectitude, able to handle their staff without abusing them. Still, there seems to be a minority of morally deviated people among radiologists having fun abusing their power and responsibility.

Determination to defend one's convictions is not a general trademark in our societies. One admires those few who stand up and state: "But not with me!", also, and in particular, among radiologists. However, this in many cases is the end of a career.

■ One sometimes wonders about the selection of leaders — in radiology and elsewhere. No doubt that many of them are excellent, but some of them reach the top and stay there when they rather should have been removed from their office at an early stage. When they are young you can talk to them and they seem reasonable — but while climbing up the ladder of power and — limited — fame they lose their ability to perceive how they behave to others and what they are doing. They believe that they are demigods and act accordingly. Because they have no integrity — which is known to everybody in their vicinity — they lose their respectability. Their domination is only kept up by intimidation, connections to same-level colleagues, and unscrupulous collaboration with commercial partners and politicians.

Usually narrations about these aberrations stay within the radiological community, but major scandals are blown up in the media: medical scientists fake results; physicians' reports are bought by companies; professors of radiology earn € 10m per year with state-financed equipment and staff.

The faith of people in the integrity of politicians, trade unionists, journalists, lawyers, and, last but not least, physicians has deteriorated during the last decades. Indifference, lack of direction, greed, lust for power in their small world leads to unethical excesses which are not penalized because of the general decay of ethical values.

Payment or compensation

Radiologists, as all physicians, are the stewards of their knowledge. As such, they have the moral obligation to introduce and educate others. They also have a moral obligation to help with their knowledge people who cannot afford their regular fees.

Of course, this holds mainly for countries such as the United States or regions of the world without a functioning public health and welfare system. However, even in western and central European and certain countries in Australasia, providing care to the poor and vulnerable should be part of our moral obligation, because in some cases the social network does not function properly. Certain groups of the population are marginalized, among them the elderly, the mentally ill, the chronically ill, the handicapped, and the uninsured.

It is unethical that, e.g. in the United States, emergency diagnosis and treatment is only provided after money has been put on the table of the emergency room. Yet, in most cases this situation is not to be blamed on the physician but on the health system as such. No doubt that enough income must be created to guarantee the livelihood of the doctor, the medical personnel, and the infrastructure of hospitals. Similar extreme situations you find anywhere between Tirana and Novosibirsk — the lack of basic equipment and accessories makes it extremely difficult to provide basic medical necessities although trained medical doctors are at hand.

The payment of a medical service is always a problem that has been solved by putting up certain fees for certain services. This is the way how a professional should be compensated.

Salaried physicians are a development of the last century which advanced hand-in-hand with social progress and health for all. Often salaries are not fair for the effort put in. In some countries one finds a combination between salaried and private practice radiologists in the same position. One patient is

treated by the state-employed radiologist, the next one as a "private" patient by the same radiologist with the same equipment and personnel. This leads to a situation where the head of a department earns a hundred times more than a resident (and often the residents do the work and the tax payer foods the expenses). This is ethical as long as everybody involved gets their adequate share of the profit.

The same holds for private offices: there should be an eventual equality of all radiologists in a group. It is also not ethical to refer a patient to an imaging center in which the referring physician (or even radiologist) has a financial interest. As always in life, there are exceptions, for instance if the examination cannot be performed elsewhere.

■ In these times of cost containment we have reached some completely opposite evolutions from those considered in earlier discussions: there might be financial advantages for the physician not to diagnose, treat or continue treating the patient. This is worse than diagnosing or treating a patient just to get the fee. No radiologist should be placed in the position of bedside rationing based on the patient's age, financial status, or terminal illness. No patient should be able to acquire organs for transplantation because of his or her financial abilities or connections.

However, decision-making often turns on political and economical not ethical grounds. A typical example is by-passing waiting list. These lists are a sad and immoral by-product of state-run medicine. They are the cause of suffering and deaths of patients. What is worse is the ways people jump the line. With money you can get into most MR, CT, or PET scanners instantaneously without a three-months wait. When you are a politician and you or some member of your family get sick, you make one telephone call and things will be arranged, even if you are the responsible for the misery of the waiting lists. This is were equality and democracy end.

The decay of authority

The British National Health System can be used as a leading example of how medical ethics were corrupted within the last half of the century.

The idea of a welfare system and access to health care for everybody is morally positive. The way of its implementation, however, was against human nature and, as such, prone to fail. In the early years of the

NHS, in the 1950s, medicine was considered a profession and most doctors at that time worked with this perception in mind. They had authority based solely upon their professional status and most of them behaved according to this status and its moral standards.

Over the years this changed. Doctors were made into salary receivers and trade union members. Part of their responsibilities was taken from them, step by step; first they lost their administrative, then part of their medical authority. There was hardly any fight against this development. Finally they became wage slaves of the health administration, without their own will and without any power against nurses and administrators (one should not generalize and paint in only black and white without any hues in between — but the general picture looks like this).

■ A doctor used to be a pillar of society and of medicine. The NHS and other welfare systems undermined this authority. This sounds awkward and old-fashioned. Isn't it good that the ancient high-and-mighty physicians have disappeared and the hierarchy has been replaced by a democratic system? Isn't this a more ethical arrangement?

We have just seen that the little dictators survive and flourish in any system. The majority, however, has lost their high standing. Because their responsibility has been limited their sense of responsibility diminishes. This has a straight and negative impact upon patients. Of course, this kind of responsibility cannot be replaced by a newly created administrative office. One can observe this decline in authority all over: in the relation between parents and children, superiors and employees, radiologists and technicians. No doubt that authority is used and abused, but it also gives protection. There is a reference person, there is an example.

Outside interference

Medicine, in particular equipment-based medicine such as radiology, has to make business sense. Not only in purely capitalistic (U.S.A.) or in social welfare health service systems (Germany, Switzerland) but also in state-run welfare systems (such as Great Britain, Scandinavia, New Zealand) radiologists are increasingly replaced by administrators.

Considering the bureaucratic workload of a physician, this can be advantageous. However, bureaucrats

always increase bureaucracy. There are unlimited stories about them aggravating the life of others. But even worse, radiology administrators increasingly are turning to vendors for help in justifying and then providing the worth of technology acquisition. This is part of the perversion of medicine today. Hospitals and the medical system have been put upside down — administrators and bureaucracies govern physicians, nurses and technicians - and patients. The work of physicians has to pay for a multitude of administrators perpetuating office tasks as in any other sphere of contemporary societies.

Ethical committees

During the last fifteen years ethical committees sprouted up like mushrooms at universities and medical schools. They were often composed of people with limited knowledge of the tasks and obligations of an ethical committee. Some believe common sense is all one needs to judge ethical questions.

Others are more pragmatic: "We invite only those people to join the committee of whom we know how they will decide ..." which is an attitude as unethical as it comes (this citation has not been invented).

Clinical studies require the approval of these committees which has had a sobering effect upon pharmaceutical companies – but only in some places. Elsewhere the show goes on under the guise of an ethical committee in which everybody has straightforward advantages of their own in their mind. "Conflict of interests? Why should I resign from the committee?"

One argument is that scientific development can and should not be hindered by moral questions or standards which do not fit in our modern times. Iceland has decided to sell the rights to the entire population's genetic code to Roche Holding Ltd., a move that most doctors and scientists in Iceland find quite unethical and unrealistic.

To end: it is very easy to talk about ethics when sitting in an ivory tower. However, one must never forget: "First comes fodder, then the morality" (Berthold Brecht: *Die Dreigroschenoper* / *The three pennies opera*, II, finale). It is very difficult to judge the moral aspects of a person. This does not mean that ethical aspects of medicine cannot be put up for discussion. Someone has proposed that together with obligatory continuing education, there should be an

obligatory ethical oath — possibly in a modern form that echoes the original's content and intent (see Appendix).

■ There are numerous other issues in radiological ethics, for instance, is it unethical that the average radiologist does not see or talk to the patient? What about teleradiology? Do we do enough to preserve the patient's dignity in an x-ray department? Or, how ethical is a medicine depending on heavy-equipment? To answer these questions one would have to write a book.

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Appendix

The Hippocratic Oath

The Hippocratic Oath is the earliest and most impressive document in medical ethics. Hippocrates (c. 460-c. 377 B.C.) separated the practice of medicine from religion, superstition, and magic.

"I swear by Apollo the physician, by Æsculapius, by Hygeia, Panacea, and all the gods and goddesses, that, according to my best ability and judgment, I will keep this oath and stipulation; to reckon him who taught me this art equally dear to me as my parents; to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing as my own brothers, and to teach them this art if they shall wish to learn it, without fee or stipulation, and that by precept, oral teaching and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to no others.

"I will follow that method of treatment, which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

"With purity and with holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption, and, further, from the seduction of females or males, bond or free.

"Whatever in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

"While I continue to keep this oath inviolate, may it be granted to me to enjoy life and the practice of my art, respected always by all men, but should I trespass and violate this oath, may the reverse be my lot."

■ Apollo, referred to as "the physician" in the opening sentence of the oath, was the patron god of the physicians of ancient Greece and Rome (as well as the god of music, poetry, prophecy, and the founding of cities).

Apollo's son, Æsculapius, became more exclusively the patron god of the physicians. Hygeia and Panacea, according to Greek mythology, were daughters of Æsculapius, Hygeia being the goddess of health, and Panacea a divine healer of all ailments.

Not strictly an oath, it was, rather, an ethical code or ideal, an appeal for right conduct. In one or other of its many versions, it has guided the practice of medicine throughout the world for more than 2,000 years.

Some duties of the oath are contrary to fundamental of Hippocratic medicine. Abortions were performed to limit and to regulate the size of families; suicide was allowed and physicians supplied poison; Hippocratic doctors were good surgeons. The oath itself is based upon Pythagorean philosophy, including parts of Hippocratic medicine.

At some universities and medical schools, the Hippocratic oath is still part of the final medical examination; in most European countries this is not the case. Parts of the Hippocratic oath are incorporated into general laws. Additional regulations within the *Corpus Hippocraticum*, a major work by Hippocrates, deal with relations to patients, furnishings of consultation rooms, compensation for the physician's services, and values of being a physician.

Declaration of Geneva

The Declaration of Geneva, adopted by the General Assembly of the World Medical Association in 1948 is a modified form of the Hippocratic Oath.

The Declaration is as follows:

"I solemnly pledge myself to consecrate my life to the service of humanity. I will give to my teacher the respect and gratitude which is their due; I will practice my profession with conscience and dignity; the health of my patients will be my first consideration; I will respect the secrets which are confided in me; I will maintain by all means in my power the honor and the noble traditions of the medical profession; my colleagues will be my brothers; I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely, and upon my honor."

Rinckside, ISSN 2364-3889

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Citation: Rinck PA. Some thoughts about contemporary ethics in medicine. *Rinckside* 1999; 10,3: 9-11.

The front and back of medical journals

Peter A. Rinck



There are tens of thousands of medical journals worldwide. Nobody knows the exact number. There are hundreds of radiological journals. I always wonder how they survive, because there is only a limited number of readers, and if you talk to the readers, hardly anyone reads thoroughly journals.

The radiological magazine *Diagnostic Imaging* is now in its 21st year, having published its first North American edition in November 1979; *DI International* first appeared in April 1983 and was renamed *DI Europe* in January 1995. For several years there has also been an Asian edition and a Latin American version in Spanish. Published under the same name, all these editions reflect, without doubt, a United States background, but have their own character according to the region of the world for which they are written.

Diagnostic Imaging is not considered one of the “serious” scientific journals fighting to be the leader in the impact-factor war, but it has its own impact factor and is listed in *Index Medicus*. Articles are not peer-reviewed by two or three referees, but they are reviewed and thoroughly checked.

There are similar journals around, and the editors of the big and smaller scientific journals are sometimes not very happy about what some of them regard as the competing “frivolous throw-away free-of-charge gazettes”.

Some contributors to *Diagnostic Imaging* were painfully made aware of this fact in the 1980s when Radiology, the world’s largest circulation scientific radiological journal, rejected their submitted papers because some of the results had been published in the news section of *Diagnostic Imaging* (a year earlier than Radiology would have published their paper). I would have considered this an excellent public relations stunt for Radiology – people were keen on reading the entire story.

However, there were other factors to be taken into account. One of the main reasons is the competition for advertising. Advertisements fill the coffers of the publishers, but in a defined market such as radiology the number of potential advertisers is limited.

Yet, many readers are looking for review journals – easy to read, with well-written overviews summarizing original contributions at scientific conferences, a high and dense information content, and enough, but not too much, to read for one month until the next issue appears. If such a journal is put together and edited properly, it will have a market in these times of information overload.

This is also reflected in the secondary use of scientific news magazines such as *DI Europe*. They are not considered citeable sources in the list of references of articles written for serious scientific journals. Increasingly during recent years, however, I have seen copies of articles published in *DI Europe* used as references in governmental, non-governmental and other institutions when health politics and economics were discussed by radiologists and by laymen.

■ For a long time, medical news magazines were not accepted as equal partners by other journals, yet their competition and attraction have been perceptible. Some scientific journals have analyzed their rivals and integrated some of their ideas into their own layout, for example *RöFo*, the journal of the German and Austrian radiological societies, which has turned from a boring scientific and provincial magazine into a well-made monthly for radiologists in Germany and Austria (and neighboring countries). Similar efforts have happened in other countries such as France or, in a different way, for instance in Britain with newsletters in parallel to scientific journals.

There is another factor in the categorization “serious/non-serious”. Scientific journals were created as, and considered to be, independent and nonpolitical. Of course, they were political in the sense that the group of editors (not the publishers) would select and influence the priorities of who was allowed to be published and what was published, but there was no or limited commercial influence upon the contents.

■ This has changed. There is commercial influence, both from potential or actual advertisers and from publishers. There is hardly any major scientific journal left which relies on subscription fees only. Shareholder value has replaced critical independence. Par-

ticularly, the big journals such as *JAMA* (*Journal of the American Medical Association*) and *NEJM* (*New England Journal of Medicine*) have been turned into money-making businesses, relying on their reputations of serious medical journals. They fit into the trend of U.S. newspapers.

Al Neuhardt, the founder of the US-American daily tabloid *USA Today* described the mission of his publication as “journalism of hope” which “doesn’t dictate. We don’t force unwanted objects down unwilling throats.” [1]

In democratic countries, however, it is the task of the press to pinpoint good and weak aspects of the state and society. In its own form, this also holds true for scientific journals. There are public and scientific developments hardly anyone wants to hear about, but somebody must have the conviction and courage to monitor and mention them. Newspapers and scientific journals that are not published as sales magazines should not be subordinated to the marketplace; their contents should not be censored for the sake of fast money. They should also allow a pluralism of information, and even more important, a pluralism of opinions, although this might be difficult within a single publication.

■ The current scandals involving *JAMA* and *NEJM* were brought to the point by Richard Horton, the editor of *Lancet*, who stated that the dismissals of the editors of *JAMA* and *NEJM* highlight “an acute crisis that is developing between the professional values of medicine and corporate values that have overtaken much of U.S. medicine in recent years”. He stressed that medical journals are sustained by the trust that readers place in them [2].

It is not only the readers but also the authors that put trust in them. Some time ago I published an article about myocardial imaging. I was quite amazed when I saw an advertisement for cardiac imaging equipment in the middle of the paper, covering half a page. When I talked to the publisher, he stated that this was completely unintentional.

In 1988, I published an article in *Radiology* on contrast and field strength in MR imaging. This article was used by a minor US-American MR equipment manufacturer, otherwise well known for suing its competitors over patent claims, to promote its products without asking me for permission. The editors of *Radiology* were never been asked either. Personally I have no problem with my results being used by com-

panies, even if they have not supported the research. However, I want to be asked first; secondly, I do not like to sponsor publishers with my work; and thirdly, I do not like to be used to promote products I would rather like to see disappear from the market.

Still, I was lucky compared to a German cardiologist who published an article on the pharmacological background of cardiac drugs. Several pharmacological companies ordered a total of 100,000 off-prints of this paper, which were promptly printed and delivered by the publisher, without paying any royalties to the author.

■ This brings us to a related topic: the rights of authors. Most scientific journals require signing a “transfer-of-copyright” agreement before an article is published. In other words, if you do not sign the agreement, the paper will not appear in the journal – a classical case of blackmail. However, by signing this agreement, you sign your soul away. All rights and all possible income go straight to the publishing company.

In many instances, the authors not only lose all rights, but they even have to pay for reprints. I have recently contributed a chapter to a book. Two years after I had submitted my contribution I wrote to the publishing house, asking what had happened to my contribution. I received as answer a letter stating that I could buy a copy of the book at a special author’s discount, but they did not even send a single reprint of the chapter. You have to pay for your own proof reprint.

Another example: Not too long ago I received an unsolicited letter from a British publisher. He sent the manuscript of a chapter for a new textbook for review, 75 pages: “I am writing to request your help in assessing the suitability of a manuscript on xyz ... I am afraid that we are in rather a rush to have this review completed and ideally, I would hope to have your review completed in one week.”

The word “please” did not appear in this letter. It was just taken for granted that I would spend a weekend to work my way through the manuscript, check it for mistakes, edit it, and make proposals for changes – for the benefit of mankind and for a new Mercedes-Benz for the publisher. This attitude is immoral and dishonest. Intellectual property is property after all – the expropriation of the author does not include the free use of the Mercedes-Benz of the publisher.

■ Thus, I would suggest to potential authors to change and return the “transfer-of-copyright” form with the following addition:

"The publishers will inform the author(s) in case they want to make use of their limited copyright. In case of sales of reprints or of other reproductions of the article in printed or electronic media, the publisher will compensate the authors financially or by other means. The authors retain the right to reject publication for purposes they deem to be conflicting with their personal or scientific integrity."

■ The special relationships between authors and publishers are a tell-tale story of many authors (although mostly of fiction books, not of non-fiction “scientific” contributions to journals).

Kurt Tucholsky, a famous German political and satirical writer of the 1920s and 1930s, once summarized the relationship between his publisher and himself as follows:

"Negotiations with the publisher. The author, at the end: 'I guess it will be best if both of us marry rich !' and hands some money to the publisher." [3]

... and the dedication of a book by the Hungaro-British writer George Mikes reads as follows:

"This book is dedicated to my friend and publisher, André Deutsch, without whose kind help I could not have managed to remain poor."

■ **Disclaimer:** Since certain people always construct connections where there are none I would like to stress that this column was written independent of and with no connection to the editors of *Diagnostic Imaging*.

■ **PS:** However, ... I thank the editors and publishers of *Diagnostic Imaging* for not censoring this column. If you want 100,000 reprints, please feel free to contact me.

■ **Footnote:** *Many years later:* In the meantime the magazine *Diagnostic Imaging* was sold and its format changed. And I stopped writing for it.

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Rinckside, ISSN 2364-3889

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Citation: Rinck PA. The front and back of medical journals. *Rinckside* 1999; 10,4: 13-14.
