NEWS IN BRIEF

Supreme Court Approves PassiveEuthanasia

"Life sans dignity is unacceptable defeat and life that meets death with dignity is … a moment of celebration." Chief Justice of India, Deepak Misra quoted Ernest Hemingway in The Old Man and the Sea as he made a landmark judgment legalizing passive euthanasia and approving "the living will." This judgment comes in the wake of a string of judgments, which are paving the way for increased individual freedom, including decriminalization of suicide.

The story begins in 2005 when the NGO 'Common Cause' filed a petition asking for permission for a 'living will' by persons afflicted with a terminal illness with no hope of survival. There was much public debate also when on a separate plea the court allowed passive euthanasia in the case of Aruna Shanbaug in 2011. Finally on March 9, 2018, the Supreme Court authorized families to switch off life support for their kins if a medical board has declared that they are beyond medical help.

A living will is a written document by way of which a patient can give his explicit instructions in advance about the medical treatment to be administered when he or she is terminally ill or no longer able to express informed consent. Passive euthanasia, meanwhile, is a condition where there is withdrawal of medical treatment with the deliberate intention to hasten the death of a terminally-illpatient. However, to prevent misuse, the Court has asked for stringent guidelines to be fulfilled by various medical boards, including experts and judicial authorities. This complex judgment has been deeply studied from all aspects – medical, metaphysical, constitutional and religious – by Chief Justice Misra and his colleagues, and an attempt has been made to uphold individual dignity at a time when as he poetically puts it "the spring of life is frozen and…life which one calls a dance in space and time has become still." (*The Times of India 10 March 2018*)

Art Classes and Medical Students

A recent study on medical students of the University of Pennsylvania has many lessons for those designing medical curriculum anywhere in the world. Students underwent training normally reserved for students of art history in the Philadelphia Museum of Art. They participated in sessions on how to look at art –thatis observe and reflect upon objects of imagination. This technique, called 'Artful thinking' begins with approaching a piece of art with introspection and observation before interpretation. After six 90-minute classes on art observation by professional art educators, they were tested along with a control group of students.

To assess the effect of art observation training, all students in the study completed pre- and post-intervention tests. The tests required students to describe in writing their observations of three different types of images: art images, retinal images, and external eye/face images involving ocular or periocular disease. For example, the rubric for retinal images included points for correctly describing specific observations of retinal hemorrhages with central hemorrhagic cyst, ocular histoplasmosis, chorioretinitis, and Stargardt's Disease. Students who participated in art training had a significant improvement in overall observational skills compared with the control group.

In the United States, now 69 of the 133 accredited Medical colleges require that a medical student take a course in medical humanities. This includes courses in literature, visual arts, theatre, philosophy,*etc.* The subliminal benefits range from improved clinical skills, inculcating empathy, and reducing stress. Becoming a good doctor is quite distinct from becoming a well-trained doctor. One needs to be conversant with the larger world of ideas for that. (*Opthalmology.2018;125:8-14*)

WHO Guidelines on Management of Latent Tuberculosis

The WHO has tried to clear some of the ambiguities surrounding prophylactic anti-tubercular therapy. So far, testing for latent tuberculosis was targeted at patients living with HIV and children below the age of 5 years who are contacts of patients with tuberculosis. The net has been expanded to include older children, adolescents and adults in contact with patients with tuberculosis and contacts of patients with multi-drug resistant tuberculosis.

Either the tuberculin test or the interferon gamma release assay may be used.Active tuberculosis may be ruled out in the absence of clinical symptoms of cough, fever, weight loss or night sweats and a normal chest *X*-ray. Testing for latent tuberculosis before starting prophylaxis is not mandatory for persons living with HIV or children below 5 years who are contacts of patients with tuberculosis.

Besides the old regimen of 6 months of daily isoniazid (INH), two new regimens have been recommended both in low and high prevalence areas of tuberculosis. One is 3-month course of daily INH and rifampicin. The other is a 3-month course of weekly rifapentin and isoniazid. In areas of high tuberculosis prevalence, adults and adolescents living with HIV and without active tuberculosis must receive 36 months of isoniazid prophylaxis, irrespective of their immune status.

Besides these guidelines, recently there has been active experimentation in the area of prophylaxis in patients with HIV. A recent study in 3000 patients with HIV has shown that a one-month course of daily rifapentin and isoniazid has been as effective as a 9-month course of INH prophylaxis in HIV patients.

In the face of a rather bleak scenario where prophylaxis against tuberculosis was received by a paltry 13% of the 1.3 million children who deserved it, the WHO guidelines are most timely. (*http://www.who.int/tb/features_archive/WHO_recommendations_TB_prevention/en/*).

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