

## FROM OTHER JOURNALS

We scan the *Annals of Internal Medicine* ([www.annals.org](http://www.annals.org)), *New England Journal of Medicine* ([www.nejm.org](http://www.nejm.org)), *Journal of the American Medical Association* ([www.jama.ama-assn.org](http://www.jama.ama-assn.org)), *Lancet* ([www.thelancet.com](http://www.thelancet.com)), *British Medical Journal* ([www.bmj.com](http://www.bmj.com)), *Canadian Medical Association Journal* ([www.cma.ca/cmaj.com](http://www.cma.ca/cmaj.com)), *Journal of Medical Ethics* ([www.jmedethics.com](http://www.jmedethics.com)) and *Eubios Journal of Asian and International Bioethics* ([www.biol.tsukuba.ac.jp/~macer/EJAIB.html](http://www.biol.tsukuba.ac.jp/~macer/EJAIB.html)) for articles of interest to the medical ethics community. For this issue of the *IJME* we reviewed the May–July 2004 issues of these journals. Articles of interest from the *National Medical Journal of India*, *Monash Bioethics Review* and *Developing World Bioethics* and some other journals are abstracted as and when they become available.

### Temporary incompetence

*How can one ensure that a mentally ill patient who is temporarily unable to make choices receives optimal treatment?*

The paper and the editorial address this difficult situation, which is different from that in which patients are permanently incompetent to take decisions. Here, patients can be temporarily incompetent. As a result of treatment—which they may reject while incompetent, but which can be forced on them against their wishes—they gain the mental competence to question the very treatment that makes them competent. In this case, patient autonomy exists but cannot be absolute. This poses an ethical dilemma as one must act in the best interest of the patient or what the patient would have wished for if able to make appropriate choices.

The authors suggest obtaining patients' advance statements giving their treatment preferences in case their decision-taking ability is later impaired. This reduces the forced hospitalisation of patients. The editorial points out that though this appears admirable, many patients in the study refused to collaborate in this joint exercise for various reasons.

Henderson C *et al.* Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMJ* 2004;**329**:136–40.  
Thomas P, Cahill AB. Compulsion and psychiatry—the role of advance statements. Liberation cannot be handed to the oppressed by the oppressor. *BMJ* 2004;**329**:122–3.

### Breaking bad news

In India, increasingly, patients with terminal cancer want to be involved in decision-making. This study shows how grim facts can be communicated sensitively. The researchers found that patients receiving palliative care valued the process of information sharing as much as the information itself. The process of communicating diagnosis and prognosis affects how information is perceived. Six necessary attributes were identified: playing it straight, staying the course, giving time, showing you care, making it clear, and pacing information.

Kirk P *et al.* What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;**328**:1343.

### Case studies and discussions on ethics

*The editorial introduces a new series of everyday cases in the British Medical Journal with discussions of the ethical issues involved. It notes that medical ethics is not a mere academic exercise but affects routine patient care. Doctors may not realise that they make value judgements as they care for patients. Yet good medical practice requires that such value judgements are properly analysed and assessed, just as scientific and technical evidence is properly evaluated. Doctors need to assess the merits of various competing courses of action, and be able to justify their decisions in ethical terms.*

The first case study concerns genetic testing of family members. The discussion notes that advances in genetics are creating more dilemmas for doctors, patients and their families as it becomes possible to prevent genetic diseases. Geneticists often find themselves in a quandary when a family member refuses to share information with others at risk. Does genetic information belong to the patient from whom it was obtained or to the whole family?

The key ethical question is whether the foreseeable harms of non-disclosure to the whole family are sufficiently serious to justify breaching patient confidentiality. Genetic testing is usually done only after assessing the family history and the results should be viewed as belonging to the family—the joint account model. Under such a model the patient would have to be at risk for serious harm to justify not sharing information.

Parker M. Getting ethics into practice: clinicians need to be able to analyse and justify their day to day value judgments. *BMJ* 2004;**329**:126.

Parker M, Lucassen AM. Genetic information: a joint account? *BMJ* 2004;**329**:165–7.

### Conflicts in genetic databases

The authors argue that fundamental personal genetic privacy may need to be compromised to develop genetic databases. They call on all people to contribute to the development of genetic research within the framework of a regulatory system that would give due weightage to social, cultural, legal and ethical considerations. They also call for cooperation between developed and developing countries.

Su B *et al.* Privacy versus public interest in developing human genetic databases. *Eubios Journal of Asian and International Bioethics* 2004;14:82–5.

### Restricting access to data

Medical researchers, specifically epidemiologists, have been allowed confidential access to medical records throughout the ages, and until recently such access without informed consent was explicitly allowed under the UK Medical Research Council's guidelines on research. Following media reports on breaches of confidentiality, the UK government proposed restrictions on researchers' access to data. The writer argues that the proposed new law will hamper legitimate and potentially beneficial research.

Peto J *et al.* Data protection, informed consent, and research: medical research suffers because of pointless obstacles. *BMJ* 2004;328:1029–30.

### Conflicts of interest

While some journals do not publish opinion pieces written by authors with declared potential conflicts of interest, the *Annals of Internal Medicine* sometimes does. The editors explain why. The primary objectives of a medical journal are to describe research accurately and to discuss interpretations and limitations fairly. For the author, the secondary objective may be anything (financial gain, a personal relationship, intellectual passion) that leads to overstating or denigrating research results, selectively withholding pertinent data or discussion, or exaggerating or minimising the shortcomings of the research. Journals typically use two main weapons to address conflict of interest: disclosure (of conflict) and exclusion (of the writer). Disclosure of conflicts is becoming universal. Exclusion may be harmful as often individuals with the greatest expertise have potential conflicts. The problem is finding a way to maximise the benefits of that expertise while minimising the risk for harm from real or perceived bias because of a potential conflict of interest. The editors of this journal use several ways to avoid undue bias in articles. They consider the transparency of the author's argument, strength of the evidence and value of the piece in stimulating discussion; they exert greater than usual editorial oversight; they may invite someone to write an article with a contrasting point of view or encourage authors who want to respond to a critique.

The editors. Publishing commentary by authors with potential conflicts of interest: when, why, and how. *Ann Int Med* 2004;141:73–4.

### Dealing with treatment-related harm

*Health care can cause harm through inadvertent errors. How one accepts and deals with these errors will determine the level of trust that patients will develop in their health care system.*

The painful paradox is that, by lavishing health care on our patients, we may also be exposing them to a potential

hazard. Patients need to be made more aware of the level of risk involved in a particular course of treatment and their complaints must guide the system. If injured, they deserve rehabilitation, explanation and even compensation. Just as employees harmed at work might expect redressal for the unwanted and possibly unanticipated risk to which they have been exposed, patients harmed at a hospital might also welcome an environment in which their claims can be heard. In New Zealand, for example, treatment injury is dealt with by the Accident Compensation Corporation as a special case of accidental harm without the need for litigation.

Davis P. Health care as a risk factor. *CMAJ* 2004;170:1688–9.

### Cross-cultural views on ethics

*Do various religions assist in the elucidation of current ethical issues in medicine? The following articles address the perspectives of Hinduism and Buddhism.*

The first article discusses the virtues of management, efficiency, dynamism and striving for excellence in the context of the holistic Hindu perspective of *lokasangraha*—for the welfare of many. The second article looks at Buddhism as a resource for discussions in modern bioethics. The Buddhist 'middle way' ethic, based on the concept of interdependence, and the Buddhist emphasis on intention as an important ingredient in ethical decisions, are useful in discussing grey areas in bioethics. The Buddhist understanding of death as a process and not an event, supports the total brain death approach, which prohibits the premature removal of organs for transplantation. The Buddhist approach to dying and acceptance of death facilitates discussions on euthanasia and care for the dying. Finally, an essay assesses the relation of Hindu religious thought, from the Hindu concepts of personhood, reincarnation and the connection between moral and social concerns to abortion ethics, and how this differs from the western debate.

Bhattachary MP. *Bhagavad Gita* and management. *Eubios Journal of Asian and International Bioethics* 2004;14:138–41.

Ratanakul P. The Buddhist concept of life, suffering and death, and related bioethical issues. *Eubios Journal of Asian and International Bioethics* 2004;14:141–6.

Moad EO. Hindu ethics on the moral question of abortion. *Eubios Journal of Asian and International Bioethics* 2004;14:101–3.

### Guidelines for cyber health care

E-health is an emerging field in the intersection of medical informatics, public health and business. It includes health services and health information delivered or enhanced through the internet and related technologies. E-health can empower lay persons to become health-literate and health-responsible, and to make educated choices about lifestyle and quality of life. However, E-health will also change the established local systems of health care and caring for patients. The authors propose a

set of interactive action guides for cyberspace health care communication and communities.

Sass HM *et al.* E-health ethics: a yet to be recognized issue in medicine and medical ethics. *Eubios Journal of Asian and International Bioethics* 2004;14:147–8.

### Debates on male circumcision

The June 2004 issue of the *Journal of Medical Ethics* carried a mini symposium on circumcision. Four of the seven essays are described here. In the lead article, ‘Irreversible bodily interventions in children’, S J Holms notes that we do not worry as much about other irreversible bodily and mental interventions to which parents subject their children. The acceptability of an intervention depends on the risk and magnitude of permanent harm—physical, and later conscious rejection of the procedure. We do not have valid comparative data on the effects of early circumcision on adult male sexual function and satisfaction. Until such data become available, the debate on circumcision cannot be brought to a satisfactory conclusion, and there will always be a suspicion that the opposition to circumcision is partly driven by cultural prejudices, dressed-up as ethical arguments. In ‘Circumcision: a surgeon’s perspective’, J M Hutson speculates on whether the practice may have evolved as a hygiene measure and then goes on to say that the most fundamental principle of surgery is that no operation should be done if there is no disease; it cannot be justified if the risk of the procedure is not balanced by the risk of a disease. The surgical argument for circumcision of all neonatal males at present is weak, and with the rising public health standards in the developed world, it is likely to remain weak. In ‘The development of professional guidelines on the law and ethics of male circumcision’, R Russell refutes the charge that the British Medical Association’s guidelines are worthless because these explore the issues without either firmly rejecting or accepting non-therapeutic male circumcision, asserting that the deliberation has been beneficial in several ways. In ‘Value judgment, harm, and religious liberty’, AM Viens argues that in the absence of sufficient evidence or persuasive argumentation, the current policy is justified, in which parents have the freedom to choose infant male circumcision.

Holm SJ. Irreversible bodily interventions in children. *J Med Ethics* 2004;30:237.  
Hutson JM. Circumcision: a surgeon’s perspective. *J Med Ethics* 2004;30:238–40.

Mussell R. The development of professional guidelines on the law and ethics of male circumcision. *J Med Ethics* 2004;30:254–8.

Viens AM. Value judgment, harm, and religious liberty. *J Med Ethics* 2004;30:241–7.

### The four principles and Islam

Little is known about teaching medical ethics across cultural and linguistic boundaries. This study conducted in an Arabic country showed that students with even a brief introduction to western medical ethics were able to identify and discuss complex ethical issues. This suggests that ‘ethical principles as espoused in the four-principle approach may be common to the students’ Islamic religious beliefs’.

Ypinazar VA *et al.* Western medical ethics taught to junior medical students can cross cultural and linguistic boundaries. *BMC Medical Ethics* 2004;5:e4

### Off-label use of drugs

A recent controversy in India concerns the off-label prescription of the cancer drug letrozole. Two editorials respond to this controversy, and to the Indian Medical Association’s (IMA) recent policy statement supporting off-label prescription. It is argued that the IMA’s policy statement was designed to defend the administration of letrozole as an ovulation-inducer. An article in the same issue argues that the prescription of letrozole was in fact an informal clinical trial by the drug company, using the help of doctors. It also describes the legal requirements for drug research in India.

Editorial. Which side of the wall are you, IMA? *BODHI* 2004;58:33–4.

Editorial. Which side of the wall are you, Bezonian? *BODHI* 2004;58:35.

Anonymous. The letrozole scandal and the lessons to learn. *BODHI* 2004;58:36–40.

### Live operative workshops

This debate between two surgeons on the value of live operative workshops outlines opposing points of view. The first author, writing in response to a letter opposing such workshops, states that while there are problems, they can be powerful educational tools. The second author argues that live operative workshops are marketing strategies with serious ethical problems.

Ardhanari R. In defence of live operative workshops. *Natl Med J India* 2004;17:99–100.

Nagral S. Live operative workshops: a critique. *Natl Med J India* 2004;17:100–2.

### Live donor liver transplantation

This editorial discusses live donor liver transplantation (LDLT)—why is it considered, and essential medical and ethical requirements. It also describes the practice of LDLT as a ‘worrying trend’ in less than ideal settings with ‘consequent greater donor morbidity and rumoured mortalities that are difficult to accept’.

Silva M, Mirza DF. Live donor liver transplantation: is this really the way liver transplantation should be developed in India? *Natl Med J India*. 2004;17:61–3.