FROM OTHER JOURNALS

We scan the Annals of Internal Medicine (*www.annals.org*), New England Journal of Medicine (*www.nejm.org*), Journal of the American Medical Association (*www.jama.ama-assn.org*), Lancet (*www.thelancet.com*), BMJ (*www.bmj.com*), Journal of Medical Ethics (*www.jmedethics.com*), Canadian Medical Association Journal (*www.cma.ca/cmaj.com*), and Eubios Journal of Asian and International Bioethics (*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 November 2004 - January 2005 issues of these journals. Articles of interest from* The National Medical Journal of India, Monash Bioethics Review, Developing World Bioethics *and some other journals are abstracted as and when they become available.*

Conflicts and conflicts

The editorial policy of the *CMAJ* is directed by International Committee of Medical Journal Editors (ICMJE) guidelines. The ICMJE statement on conflict of interest names two main sources of bias in medical journal publications – financial and personal relationships.

Authors in the *CMAJ* were more likely to declare conflicts of interest concerning the nature of their personal relationships with colleagues and competitors. They declared disclosures of financial interests less frequently. In the late 1990s, *CMAJ* revised its conflict of interest policies by asking authors who mentioned a commercial product specific questions about their financial support – travel to meetings, research support, honoraria, investments, royalties and patents.

But is disclosure sufficient? When, if ever, are financial conflicts of interests so great that publication ought to be refused even if they are disclosed? On this matter the ICMJE guidelines are silent.

The editorial suggests distinguishing between types of manuscripts. Original research has more safeguards against bias -- scientific methodology, peer review, ethics review. Narrative reviews and commentaries are built on selected references and interpretations; bias in these articles is always possible and often difficult to detect. Some journals have tried – unsuccessfully – to limit commentary and review articles to those with no financial ties to commercial sponsors. Others have stated a level above which a conflict of interest would prohibit publication. *CMAJ*'s new policy is an amalgam and will continue to be modified as they learn from readers and editors.

Editorial. Conflicts of interests and investments. *CMAJ* 2004; 171: 1313.

Medical journals and politics

The writer argues that medical journals have a duty to highlight concerns about abuses of state power; medicine cannot exist in a political void. The *BMJ* believes that "any issue has a health angle in the same way that the *Economist* has shown that any issue has an economic one."

Abbasi K. Should journals mix medicine and politics? *BMJ* 2004;329: 1136.

Medical journals and the media

When medical research is reported in the popular press, it can put pressures on physicians, researchers and editors of medical journals. How does one communicate the complexities of a given study, the practical problems of its application, and the trade-offs, in a news article so as to avoid patients' unrealistic expectations or unnecessary anxieties? Journalists are ready and waiting to report on research. The writer argues that medical journal editors must undertake rigorous peer review and critical examination of how researchers interpret their findings. They should go to great lengths to provide accompanying expert commentary so that reporters get a balanced view of the research in question.

Campion EW. Medical research and the news media. *New Engl J Medicine* 2004; 351:2436-2437.

Do journals look at the developing world?

Health research is focused on the diseases of 10% of the world's population Medical journals cannot single-handedly set this inequity right but they have an important role to play. The authors review the contents of four leading medical journals and examine their relevance to developing countries. They conclude that the UK journals contained more relevant articles than did the US journals, and recommend regular audits of leading medical journals for content relevant to developing countries.

Raja AJ et al. Transatlantic divide in publication of content relevant to developing countries. *BMJ* 2004; 329: 1429-1430.

Editors must be proactive

The ICMJE and the World Association of Medical Editors set out statements on the responsibilities of editors. More recently, the Committee On Publication Ethics launches a new code of conduct for editors. These include standards for good editorial conduct such as ensuring quality of published material, describing the peer review process and declaring editorial conflicts of interest. The Code also goes one step further, to include the duty to pursue allegations of research misconduct. Editors might be tempted to reject papers of dubious integrity, rather than embark on a potentially troublesome and protracted investigation. COPE takes the view that this is not acceptable.

Godlee F. Dealing with editorial misconduct. *BMJ* 2004;329: 1301-1302.

Genetic testing for violent tendencies

This US-based study was conducted to look at the attitudes of parents and health-care professionals towards genetic testing for a tendency towards violent behaviour, a test that is currently unavailable but might become available in the future. Doctors tended to medicalise behavioural genetics, and were concerned about the potential harm of such information because no clear treatment was available. Parents wanted genetic testing anyway;

some felt the information would help their understanding and could be used to support changes to the child's environment.

Campbell E et al. Attitudes of healthcare professionals and parents regarding genetic testing for violent traits in childhood. *J Med Ethics* 2004; 30: 580-586.

Ethical screening programmes

There is a great potential for translating advances in medical genetics into effective, population-based programmes. The editorial writers illustrate this with the case of Iran's national thalassaemia screening and genetic counselling programme. The service was developed in a holistic way, with widespread public education, public health surveillance, and in response to the needs and wishes of the affected population and society. Religious leaders were consulted and involved. The programme resulted in a 70% reduction in the expected annual birth rate of affected infants. The writers point out that such screening programmes must comply with societal values, and the public must understand the programme's aims and objectives. If this is not done, misunderstandings will lead to stigmatisation and rejection of screening by the populations targeted.

Christianson A et al. Lessons from thalassaemia screening in Iran. *BMJ* 2004;329:1115-1117.

Buddhism and cloning

What does Buddhism think about technologies such as human cloning and embryonic stem cell research, which have many implications on the interpretation of human life and its value? The author notes that Buddhism does not use the notion of 'naturalness' to decide on whether a technology is moral or otherwise. In general, natural things in the Buddhist perspective include both what is given by nature and what is created by human technology. Ethical debates on cloning and stem cell research are linked to abortion. The author illustrates how abortion can be seen from various perspectives within Buddhist philosophy – even as it holds that abortion is wrong.

Promta S. Human cloning & embryonic stem cell research: a view from Theravada Buddhist morality. *Eubios Journal of Asian and International Bioethics* 2004; 14: 197-199.

Obstacles to the 3x5 initiative

The WHO's "3 by 5" initiative aims to deliver antiretroviral drugs to 3 million people with AIDS in developing countries by 2005. The authors identify some of the challenges faced by the initiative, focusing on delivery of care. Some of the biggest obstacles relate to continuity of care, stigma and discrimination, systems of delivery, community involvement and access to treatment. The authors argue that the initiative will have to develop a chronic disease model of care through a strengthened public health infrastructure; cooperation is needed with existing essential programmes to manage scarce health staff; the influence of stigma requires monitoring, and access to treatment must be based on rights and not ability to pay.

Furber AS et al. Barriers to better care for people with AIDS in developing countries. *BMJ* 2004; 329: 1281-1283.

Paying for research

The writer describes her experience undertaking a study related to anaesthesia. Typical of developing countries, patients recruited as research participants not only paid for their treatment but also funded the research component of their treatment.

There are many ethical conflicts in this common practice: the researcher makes a career gain from the study; the physician's primary duty to the patient is compromised; the doctor-patient relationship is exploited and patients are less able to refuse participation; and they bear the cost of the research and the inherent risks, with little or no additional direct benefits to themselves.

The writer calls for recognition of this problem, for the development of appropriate informed consent procedures, for institutions to support research, and for a change in the 'publish or perish' climate.

Khan Robyna I. Paying the price of research SciDev.Net November 10, 2004 http://www.scidev.net/dossiers/index.cfm?fuseaction=dossierreaditem&dossier=5&type=3&itemid=331&language=1

What ethics review is all about

This article suggests that while ethics committees might be a safety net for grossly unethical research, they are not the truly thoughtful bodies needed to ensure ethical research. This is frightening because committee decisions dilute responsibility at various levels. EC members uncomfortable with a decision let it pass because the others have agreed. Researchers, too, are free from responsibility once the EC passes the proposal, with the mandatory changes to the consent form and so on.

"Perhaps the most essential preparation for members of research ethics committees is not studying the content of the Statement or the relevant law, but undertaking a week of intensive training in critical thinking. Perhaps we all must consider how best to deal with situations about which not all agree, and about which objections are morally relevant. Furthermore, there are many issues that are not well addressed by guidelines or law."

Loff Bebe and Black Jim. Research ethics committees: what is their contribution? *Med J Aust* 2004; 181: 440-441.

Need 'zero tolerance' of cheating

Academic dishonesty is widely prevalent in many Indian medical colleges. It can range from copying at exams to cooking up records, cooking up data, forging teachers' signatures, proxies' attendance, plagiarism, and so on. For faculty and administrators, dishonesty can range from tolerating dishonesty to actively promoting it by tampering with marks or falsifying records to meet regulatory needs. It is done in different ways by good students and bad, by under-graduates, post-graduates, faculty and administrators. It is condoned; much of it is so open that it would be stopped with rudimentary supervision. The author calls for a 'zero tolerance' policy and suggests various responses including an institutional policy on academic honesty with a list of punishments.

"The 'unchallengeable honesty' and commitment seen in most of the faculty of yesteryears may still be seen in a handful of individuals in every institution. It is up to these individuals to curtail the current rot that pervades the medical establishment in India."

Gitanjali B. Academic dishonesty in Indian medical colleges. *J Postgrad Med* 2004;50:281-284.

May pharmacists refuse to fill a prescription?

Pharmacists have sometimes refused to fill prescriptions for emergency contraception, citing personal moral grounds. This raises important questions about individual rights and public health. The article presents the arguments in favour of patients' rights to the drug as well as pharmacists' right to conscientious objection. They conclude that although health professionals may have a right to object, they should not have a right to obstruct.

Cantor J et al. The limits of conscientious objection – may pharmacists refuse to fill prescriptions for emergency contraception? *New Engl J Medicine* 2004; 351:2008-2012.

Polish up your prescriptions

This article describes the quality of prescriptions by medical practitioners, based on a seven-day survey of prescriptions dispensed at a busy pharmacy in Goa.

Almost 84% of the 990 prescriptions collected were from private practitioners. Information to identify the practitioner was incomplete in more than a third of the prescriptions; information to identify the patient was incomplete in more than half the prescriptions. The majority of written instructions did not give clear instructions on how to take the medicines.

More than half the prescriptions contained at least three medicines; 40% included a vitamin or tonic preparation and one quarter included an antibiotic and an analgesic. Over 90% of prescriptions contained only branded medicines. Private practitioners prescribed significantly more medicines and were more likely to prescribe vitamins and antibiotics, and branded medicines.

Patel V et al. Irrational drug use in India: a prescription survey from Goa. *J Postgrad Med* 2005;51:9-12.

Campaign against unsafe injections

A safe injection is one that is medically indicated and that does not harm the recipient, the provider (through needle stick injury) or the community at large (through unsafe management of sharps waste). According to WHO estimates people in developing and transitional countries receive an average of 3.4 injections per year. Of these, 39% were given with unsterilised but reused injection devices, believed to account for 22 million hepatitis B virus infections, 2 million hepatitis C virus infections and 260,000 HIV infections in the year 2000.

This is preventable by implementing national policies to decrease injection overuse; teaching safe injecting practices, providing the necessary equipment and supplies, and managing sharps waste.

The authors describe the progress of such policies in India since the late 1990s when studies suggested that unsafe injections were a substantial public health problem. One result is that the national immunisation programme will use auto-disable syringes.

However, this is just a beginning as the majority of unsafe and unnecessary injections are administered in the private sector. Most physicians realise that injections are overused, but believe patients want them and there is nothing they can do about it. In fact, the authors note, a large body of evidence suggests that prescribers can effectively influence injection use. Most patients are open to alternatives to injections if their doctors take the time to explain to them that oral medication will be sufficient or that they do not require any treatment at all.

Yvan J F et al. Acting upon evidence: progress towards the elimination of unsafe injection practices in India. *Indian Pediatrics* 2005; 42:111-115.

When you can't explain the symptoms

Many doctors are uncomfortable managing patients whose physical symptoms cannot be explained medically. As a result, they may downplay the importance of these symptoms, or ignore the associated distress. The result is dissatisfied patients, who may go shopping for another doctor. Between 17% and 46% of patients at primary care facilities suffer from common mental disorders. The author, a psychiatrist, proposes a protocol for managing patients with unexplained medical symptoms, consisting of building a therapeutic relationship, providing alternative explanations, suggesting therapeutic options and offering continued support.

Jacob K S. A simple protocol to manage patients with unexplained somatic symptoms in medical practice. *Natl Med J India* 2004; 17: 326-328.