FROM OTHER JOURNALS

We scan the Annals of Internal Medicine *(www.annals.org),* New England Journal of Medicine *(www.nejm.org),* The Lancet *(www.thelancet.com),* British Medical Journal *(www.bmj.com),* Journal of Medical Ethics *(http://jme.bmjjournals.com),* Canadian Medical Association Journal *(www.cma.ca/cmaj.com) and* Eubios Journal of Asian and International Bioethics *(http://www2.unescobkk.org/eubios/EJAIB.ht) for articles of interest to the medical ethics community. For this issue of the* IJME *we reviewed the August 2005 - October 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.*

Data privacy can compromise research findings

The authors, through their observational study of the consequences of intracranial arterio-venous malformations, show how the modern era of data privacy in the UK can seriously prejudice the findings of observational research. Such research is essential to planning effective treatment for and prevention of complications of a chronic disease.

Al-Shahi R, Vousden C, Warlow C. Bias from requiring explicit consent from all participants in observational research: prospective, population based study. *BMJ* 2005;331:942

Ethics needs to be scientific

The author argues that while theoretical social and philosophical perspectives on clinical care and biomedical research are important, bioethics needs to use epidemiological methods to study human behaviour before evolving positions on ethical controversies. This method is akin to conducting clinical trials where clinicians study the response to various treatments before choosing the optimally effective one for a particular disease. The five rapid responses that follow this article disagree. One of them notes: "We may believe that science offers an objective, value-free, neutral position. But in as much as this is true, it is a view from nowhere. The crucial thing about ethics is that it deals with value judgements and duties which cannot be resolved in a test-tube."

Halpern SD. Towards evidence based bioethics. *BMJ* 2005; 331: 901-3.

The disaster-stricken are especially vulnerable

While acknowledging that post-trauma research is important and can be done ethically, the authors highlight the greater vulnerability of populations in developing countries. The authors appeal to journal editors to insist on proof of ethics approval and also an English translation of the information leaflet and informed consent form given to the participants, to ensure that the participants knew it was research when they participated.

Sumathipala A, Siribaddana S. Research and clinical ethics after the tsunami: Sri Lanka. *Lancet* 2005; 366: 1418-20.

Experiences in contracting health service delivery

Contracting with non-state providers is often seen as arising out of an ideological desire to privatise publicly-financed health services and ultimately to limit or end government involvement in health care. However, experience has shown that money alone will not solve the problem of poor delivery of health care The authors review 10 instances in six developing countries where contracting with non-profit NGOs has produced significant and sustainable results in health outcomes. They discuss the different types of contracting, the benefits of each type and the potential for sustaining and expanding such efforts.

Loevinsohn B, Harding A. Buying results? Contracting for health service delivery in developing countries. *Lancet*. 2005; 366: 676-81.

Improving the quality of health care

The authors argue that the focus on reporting accidental deaths captures the public's attention, leading to an emphasis on patient safety and the prevention of such deaths. But focusing on individual deaths oversimplifies the causal realities of iatrogenic injuries and makes excessive promises on the achievable gains. In contrast, quality improvement tracks changes in populations over time, and measures the "statistical lives" saved. But as it does not make clear precisely who benefits from the practice, it is difficult for the public to appreciate. The authors suggest several measures to incorporate patient safety as part of the larger goal of improvement in quality of health care.

Brennan TA et al. Accidental deaths, saved lives and improved quality. *N Engl J Med* 2005; 353:1405-1409.

Brain drain of nurses and doctors – 1

Nurses from developing countries in Asia and Africa are migrating to the USA in large numbers with deleterious consequences for the health care systems in their countries of origin. The USA may solve its shortage of trained nurses in the short term but long-term problems remain. The authors discuss what the countries of origin and developed countries can do to resolve this crisis.

Chaguturu S, Vallabhaneni S. Aiding and abetting --nursing crises at home and abroad. *N Engl J Med* 2005; 353:1761-3.

Brain drain of nurses and doctors – 2

This article continues the same theme as the article above but focuses on physician migration. The authors acknowledge that "simply blocking migration is neither effective nor ethical, since freedom of movement is a basic human right." They note: "The first responsibility for action belongs with each country to 'train, retain, and sustain' its workforces through national plans that improve salaries and working conditions, revitalise education, and mobilise paraprofessional and community workers whose services are demonstrably more cost-effective and who are less likely to emigrate." They argue that "managing international medical migration ultimately will require global political consensus" and suggest ways to initiate such a dialogue.

Chen LC, Boufford JI. Fatal flows – doctors on the move. *N Engl J Med* 2005; 353: 1850-2.

Need to learn from society

The word "cultural competence" is currently in great use in the

US to denote sensitivity of physicians to the humanistic needs of their patients. Over the last century in the US, medical educators have struggled with how to teach the "social", "psychosocial", "humanistic", "behavioural:", "non-biomedical", and "ethical" components of health and illness. The author argues that if medical educators can see the characteristics of their own society and culture they will appreciate the commonalities and differences with the cultures of their students as well as their patients.

Fox RC. Cultural competence and the culture of medicine. *N Engl J Med* 2005; 353: 1316-9.

The Indian patent law and antiretroviral drug availability

The authors discuss the dampening effect of the Indian patent amendment law of 2005 on the manufacture of generic antiretroviral drugs. These drugs are affordable for patients living in many developing countries. Generic antiretroviral regimens work quite well for many patients but new medications are needed if the benefits are to be sustained over decades. Thus, we need to provide incentives for major pharmaceutical companies to continue to develop newer antiretroviral drugs for the long-term benefit of HIV-infected people globally. Therefore, protection of intellectual property rights and tiered pricing arrangements are essential to allow both brand-name and generic pharmaceuticals to coexist and prosper.

Havlir DV, Hammer SM. Patents versus patients? Antiretroviral therapy in India. *N Engl J Med* 2005; 353:749-751.

Need to regulate innovative organ donation promotion efforts

In 2004 a non-profit website based in the US, MatchingDonors.com, was formed that allowed recipients and potential donors to communicate with each other to facilitate organ donation. The author discusses why this enterprise needs to be regulated by the United Network for Organ Sharing, an organisation which has developed processes over the last 20 years to prevent unethical donation by a living donor to a specific person.

Truog RD. The ethics of organ donation by living donors. *N Engl J Med* 2005; 353: 444-446.

Need for guidelines about paying research participants

The authors assessed the practice of paying research participants in Australia through a questionnaire mailed to diverse types of research organisations. They found that in general there were no written policies to guide researchers. Payment practices were highly variable. They were mostly monetary, for reimbursement of out-of-pocket expenses and the extra time involved. They conclude that clearer guidelines are needed in this area and that ethics committees have an important role in supporting the development of such resources.

Fry CL et al. Paying research participants: a study of current practices in Australia. *J Med Ethics*. 2005; 31:542-7.

Arbitration and mediation works better

In Mexico since 1996 all cases of complaints against doctors or hospitals are handled by an independent entity, Conamed, which mediates and arbitrates to resolve the dispute. About 70 per cent of complaints are resolved outside the courts in a system that is faster and less expensive with both patients and doctors satisfied by the results. This has helped to maintain trust between patient and doctors and reduced defensive medicine.

Tena-Tamayo C, Sotelo J. Malpractice in Mexico: arbitration not litigation. *BMJ*. 2005;331:448-51.

Opt-out approach better in observational research studies

Though ethics committees are becoming stricter about the recruitment of patients in observational research studies, authors argue that this skews the data preventing an accurate assessment of the problem. Their study showed that the patients were significantly different under the two approaches of recruitment and they make a case for the "opt-out" approach in studies that have a low risk to the patients.

Junghans C et al. Recruiting patients to medical research: double blind randomised trial of "opt-in" versus "opt-out" strategies. *BMJ* 2005;331:940.

Addressing distributive justice in emergency medicine

When traditional virtue ethics is applied to clinical medicine, the goal is the good of the individual patient. As emergency physicians often take care of several patients simultaneously, caregivers have to make wise decisions about the time, financial resources, and their own energy. An alternative model of virtue ethics which includes these issues of distributive justice is elaborated by the authors.

Girod J, Beckman AW. Just allocation and team loyalty: a new virtue ethic for emergency medicine. *J Med Ethics* 2005;31:567-70.

Is waiver of informed consent in emergency research an informed decision?

In 1996, the US government published regulations that allow investigators to obtain a waiver of informed consent for emergency research when the participants are unable to give consent as a result of their medical condition, and the intervention involved in the research is to be administered before consent from the participants' legally authorised representative is feasible. The Institutional Review Board has the freedom to determine the form and extent of the research after "community consultation" and "public disclosure". The author reviews the effect of these regulations on research.

Richardson LD. The ethics of research without consent in emergency situations. *Mt Sinai J Med* 2005;72:242-9.

Doctors and the death penalty

August 14, 2005, marked the first anniversary of the execution of Dhananjoy Chatterjee, the first execution in India after nine years. The author debates the role of the medical profession in the death penalty focusing on the Indian context. Physicians, especially those working in jails, are often involved in the medical care of prisoners, including those on death row. Jail doctors might also be asked to do pre-execution fitness examinations and need to be present during the execution to certify death. This is against the basic tenets of the medical profession. Various medical associations including the World Medical Association

have opposed it. The author calls upon the Indian medical fraternity to stop participating in the death penalty.

Bhan A. Killing for the state: death penalty and the medical profession a call for action in India. *Natl Med J India* 2005;18:205-208.

Medical education in peril

The author expresses his anguish at the state of contemporary practice of medicine in the country, with academic dishonesty and declining ethical standards for practice. Doctors solicit bribes for priority in care, split fees and take commissions from drug companies and laboratories. Drawing on a quote from a former director of the All India Institute of Medical Sciencess, who felt that medical education in India was making students "technical literate" but not "educated", the author feels that medical colleges have failed in their mission, with increasing privatisation, falling academic standards, and the impact of a rising student intake on the teacher-student ratio. Censuring the Medical Council of India, the author argues that the apex licensing body has encouraged a "license-permit raj" in medical education. There is a need for quality improvement in medical education. The contemporary physician should be expected to be sagacious, skilful and virtuous.

Kartha CC. Anguish of a medico. *Curr Sci* 2005; 89:725-6.

The National Rural Health Mission: cure for all ills?

The country's vast public health infrastructure has not been able to take care of the needs of the population, with 80 per cent of health care needs provided by the private sector. The urban-rural inequity in health care has led the government of India to launch the National Rural Health Mission (NRHM). Launched in April 2005, the NRHM is to focus on 18 states with poor public health indicators. Trained, Accredited Social Health Activists (ASHA) are to act as links between health centres and the villages. The scheme is envisaged to run till 2012. The authors point out the constraints of the scheme. Among them: a lack of operational feasibility studies and insufficient attention to learning from the failures of previous programmes. The authors feel that the ASHA scheme is similar to the Village Health Guide scheme launched in 1977, which flopped. They also question the lack of coverage for the rising urban population. Suggestions are made to improve the functioning of the scheme through the active participation of medical college faculty and user-friendly guidelines. There is a need to focus on people's needs rather than just promote vertical programmes.

Kapil U, Choudhury P. National Rural Health Mission (NRHM): will it make a difference? *Indian Pediatr* 2005;42:783-6.

Irrational and widespread antibiotic usage seen in paediatric practice

Only a small proportion of children attending outpatient clinics with complaints such as Acute Respiratory Infections (ARIs), watery diarrhoea, and viral fever require antibiotics. There is, however, widespread inappropriate use of antibiotics. The authors conducted a cross-sectional study in Chennai. 403 prescriptions by 40 physicians from selected health facilities were analysed. 79.9 per cent of children with ARIs and acute watery diarrhoea were prescribed antibiotics; the presence of fever was considered a significant factor for antibiotic prescription. Penicillin (43.9 per cent) was the commonest antibiotic prescribed, while second- and third-generation cephalosporins were used in 4.9 per cent of patients. Factors such as the physician's postgraduate qualification, experience, source and method of updating knowledge and the presence of fever were found to be influences in the prescription of antibiotics. The authors conclude by requesting professional bodies to address this important issue and also counter the inappropriate information provided by pharmaceutical companies.

Bharathiraja R et al. Factors affecting antibiotic prescribing pattern in pediatric practice. *Indian J Pediatr* 2005; 72: 877-879.