FROM OTHER JOURNALS

We scan the Annals of Internal Medicine *(www.annals.org),* New England Journal of Medicine *(www.nejm.org),* 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 InternationalEthics *(www.unescobkk.org/index.php?id=2434) for articles of interest to the medical ethics community. For this issue of the* IJME *we reviewed the Feb 2007 - April 2007 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.*

Telling the truth

Simply giving facts to patients is not enough; they should be given in a way that the patient understands the facts. Cultural context should also be kept in mind. Doctors often skirt the truth to avoid conveying distressful facts; they want to avoid a discussion that is painful to them as well as the patient. The author suggests that using metaphors could make truth telling less distressful and also make it more understandable.

Kirklin D. Truth telling, autonomy and the role of metaphor. *J Med Ethics* 2007; 33: 11-4.

Condemning child abandonment

The author debates the different ways in which child abandonment is treated by society, where some forms are punished while others are condoned. He discusses why sperm or ovum donation and giving up a child for adoption are not abandonment. He thinks that society is failing by not labelling a parent's behaviour as child abandonment when she/he simply walks away from their responsibility. He feels that this behaviour ought to be punished strongly even if the child has another parent and is not abandoned in the strict sense of the term.

Giordano S. Crimes and misdemeanours: the case of child abandonment. *J Med Ethics* 2007; 33: 28-34.

Rewarding psychiatric patients

The Assertive Outreach team focuses on psychiatric patients who have a high risk of failing appointments and are likely to end up in the hospital. The team rewards patients with money for getting injections of psychiatric depot medications. The author describes the ethical concerns of team managers towards this practice even though the practice has clearly been beneficial for the clients.

Claassen D. Financial incentives for antipsychotic depot medication: ethical issues. *J Med Ethics* 2007; 33: 189-93.

Streamlining clinical trials in India

India is attractive to pharmaceutical companies who want to test drugs because it has some of the necessary infrastructure to conduct clinical trials cost effectively. However India lacks some key elements such as functioning ethics committees in hospitals, a literate patient population, and a national body with regulatory authority that can promptly address ethics violations. The editorial suggests ways to correct these deficiencies.

Editorial. Strengthening clinical research in India. *Lancet* 2007; 369:1233

Soliciting organs

The shortage of transplantable organs has led to recipients directly soliciting organs from donors or their families, bypassing other recipients on the waiting list. The author describes why such solicitation is unethical.

Hanto D W. Ethical challenges posed by the solicitation of deceased and living organ donors. *N Engl J Med* 2007; 356:1062-6

Dichotomy in ova donation

In the US, women who donate ova to fertility clinics for treatment of infertile women can get substantial financial rewards, but if they donate the ova for stem cell research then they are not allowed by law to get money except for actually incurred out-of-pocket expenses. The author discusses the absurdity of this dichotomy and suggests changes to the current regulation.

Spar D. The egg trade - making sense of the market for human oocytes. *N Engl J Med* 2007; 356:1289-91

Policies to prevent work-related disease

Prevention of work-related injury and disease has been traditionally based on identification, measurement, and control of chemical, physical, and biological risk factors in the workplace. But when the worker is the one who is posing a hazard to the "recipients" of the work - patients -new techniques, procedures, and specific policies are necessary. The author describes the problems faced by the physician, patient, and society and suggests that hospital-wide policies are needed to address such situations rather then the current practice of dealing with them on a case by case basis.

Magnavita N. The unhealthy physician. *J Med Ethics* 2007; 33: 210-4.

Informing voluntary blood donors

Blood banks prefer to obtain blood from voluntary donors because they are likely to have a lower rate of transfusion-transmitted infections (TTI). The results of tests to determine the presence of TTI do not become available for at least three hours after the blood has been donated and the donor has left the blood bank. The blood bank must then contact the donor to inform her/him of the abnormal results. Though blood bank policies advocate informing voluntary donors, in practice, the bank simply discards the donated blood and keeps silent. This is detrimental for the health of the donor and it is also unethical. The authors suggest ways to inform donors while maintaining confidentiality.

Choudhury L P, Tetali S. Ethical challenges in voluntary blood donation in Kerala, India. *J Med Ethics* 2007; 33: 140-2.

FGM banned in Italy

Female genital mutilation is practiced in certain countries, predominantly in Africa and in West Asia, as a religious and social custom. It is being increasingly recognised in the West due to immigrants who have either been subjected to it in their countries of origin or because they want to continue the custom in their adopted countries. Recently, Italy passed a comprehensive law to ban this practice as it violates the physical and mental health of women and girls. Apart from encouraging many avenues to disseminate information about the harm of the practice, the government places special emphasis on the doctor's role in educating people and eradicating the practice.

Turillazzi E, Fineschi V. Female genital mutilation: the ethical impact of the new Italian law. *J Med Ethics* 2007; 33: 98-101.

Defining death in Japan

The point of death could be defined as the cessation of cardio-respiratory function or cessation of brain activity. Many people may accept one definition but not the other depending on their views or religious background. Japan is unique in allowing a person to choose the definition irrespective of their family's choice. The author discusses why this way may be superior and could be adopted into legislation by other countries.

Bagheri A. Individual choice in the definition of death. *J Med Ethics* 2007; 33: 146-9.

Immigrating doctors in Pakistan

The authors, physicians affiliated with academic institutions in Pakistan, discuss why doctors from Pakistan migrate abroad and why a small number make the reverse journey. They assert that these returning doctors can contribute in a major way to upgrading the parent country's medical facilities and therefore their comments should be given serious consideration.

Shafqat S, Zaidi A K. Pakistani physicians and the repatriation equation. *N Engl J Med* 2007; 356: 442-3.

Morality and treatment

Should physicians give information to patients about treatments that they object to on moral grounds, such as abortion, adolescent contraception, terminal sedation, etc? The majority, in a survey of 2000 US physicians, expressed that physicians should state their moral objections to the patient but also refer the patient to another physician who could provide the necessary treatment.

Curlin F A, Lawrence RE, Chin MH, Lanos JD. Religion, conscience, and controversial clinical practices. *N Engl J Med* 2007; 356: 593-600.

The doctor as gatekeeper?

Firth argues that though he has a duty towards his patient, he also has to follow the rules of his employer that forbid him from prescribing treatment outside the accepted protocol. If the patient has no way to obtain the treatment outside the protocol, then making him aware of the potential treatment only increases his unhappiness. Marcus states that it is not the responsibility of the physician to act as a gatekeeper for the financial services. He must abide by his responsibility to the patient, provide him with the relevant information, and let the patient make the appropriate choice.

Firth J. Should you tell patients about beneficial treatments that they cannot have? No. *BMJ* 2007; 334:827; Marcus R. Should you tell patients about beneficial treatments that they cannot have? Yes. *BMJ* 2007; 334: 826.

Good palliation or slow euthanasia?

Often terminal sedation is used during withdrawal of artificial nutrition and hydration. Is this a good palliative intervention or slow euthanasia? The author begins by defining the intervention: terminal sedation is sedation that is continued until death occurs. He describes how the state of the patient and the intent of the doctor determine if this mode of treatment is good medical practice or is active voluntary euthanasia.

van Delden J J. Terminal sedation: source of a restless ethical debate. *J Med Ethics* 2007; 33: 187-8.

Implications of licensing

Discussing the compulsory licensing by Thailand of Efivarenz in November 2006, the author explains the reasons that made Thailand take this step and how it is likely to affect other developing countries' negotiations with pharmaceutical companies for other expensive drugs.

Steinbrook R. Thailand and the compulsory licensing of Efavirenz. *N Engl J Med* 2007; 356:544-546.

Avoiding restrictive patents

Novartis has filed a case in an Indian court against generic production of its high priced drug. India changed its patent law in January 2005 to comply with WTO regulations. This change may affect Indian companies' ability to manufacture and sell cheaper versions of expensive drugs to developing countries, but India has included several provisions in its patent law that will allow it to bypass the restrictive rules if public health demands it.

Mueller J M. Taking TRIPS to India-Novartis, patent law, and access to medicines. *N Engl J Med* 2007; 356:541-543.

Informing patients about risks

How does a doctor decide which risks of a procedure or drug should be communicated to the patient? As information expands, even minor risks are listed in the literature. Several doctors were interviewed in this study to determine how they would communicate this information to their patients. The majority opinion was that if an alternative is available to the proposed intervention, then even low risks should be communicated; this was true also when the potential complication was likely to be serious. In other situations, the doctor emphasised that no intervention is without risks and encouraged the patient to gather as much information as they want.

Palmboom G G et al. Doctor's views on disclosing or withholding information on low risks of complication. *J Med Ethics* 2007; 33: 67-70.

Rural health care in the US

Medical care in rural areas of America has to face unique

challenges such as poor access to health care, lack of confidentiality as health care workers and patients live in close proximity, limited economic resources, etc. The authors describe the deliberations of a conference held to address the ethical issues that arise in the rural health care setting.

Nelson W et al. A proposed rural healthcare ethics agenda. *J Med Ethics* 2007; 33:136-139

Why do doctors participate in interrogation?

This essay on narcoanalysis discusses the disturbing trend of medical professionals getting involved in unscientific interrogation practices that violate human rights. The writer sees TV footage of a mental health professional asking questions to a semi-sedated Telgi and this triggers off memories of witnessing a policeman beating a suspect. The author notes that the police may have their own reasons for doing what they do but asks, "why are mental health professionals, who should know better, conniving?"

Numerous studies of narcoanalysis have confirmed that it does not work. A review in the American Journal of Psychiatry concluded: "For ethical reasons the psychiatrist is advised against performing narcoanalysis when the examination is requested as an aid to criminal investigation." Despite this, it has become popular in India. The Indian police first used narcoanalysis in Gujarat following the burning of a train bogie and the subsequent massacre of Muslims. Seven people were subject to narcoanalysis by doctors from a medical college. Since then it has been used frequently in high profile criminal cases with a lot of publicity in the media. The team typically consists of a psychologist, an anaesthetist, and the representative of a security agency. The results of narcoanalysis are not admitted as evidence in any country in the world.

The author summarises the history of discussions on narcoanalysis. The Bombay High Court has ruled that narcoanalysis, brain mapping, and lie detector tests do not violate constitutional rights. Various international organisations and professional associations have passed resolutions against the participation of medical professionals in torture. Even the Code of Medical Ethics of the Medical Council of India states that doctors will not be party to torture, though the MCI did not speak up when narcoanalysis started in India. On the contrary, Indian doctors have even effusively discussed details of narcoanalysis on TV. The author concludes that the reason doctors participate in this unscientific and unethical practice is "simple narcissism": "You get to wear white coats on TV and save the nation from serial killers at the same time."

Kala A K. Of ethically compromising positions and blatant lies about 'truth serum'. *Indian J Psychiatry* 2007; 49:6-9

Lethal injection is not 'humane'

The editorial discusses a research article in the same issue of the journal commenting on three protocols used in lethal injection. Lethal injection is the current method of execution in most states in the US, and in most countries where the death penalty is still practised. The procedure was conceived of by a medical professional as a humane method of execution. It is usually implemented by a non-medical person; various medical associations have banned their members from playing a causative role in executions. This means that lethal injection procedures are often botched by untrained staff, with blocked IV lines, wrong dosages and other errors.

But the researchers found that even if the protocol is followed carefully, it does not always cause death without inflicting inhumane punishment. Prisoners being executed have continued to breathe, their hearts have continued to beat, which meant they would have experienced asphyxiation while conscious and paralysed and possibly suffering intense pain.

The editorial writers emphasise that the research study does not imply the need for research to "improve" lethal injection protocols. Such human research would violate the Declaration of Helsinki. Instead, "The data adds to the evidence that lethal injection is simply the latest in a long line of execution methods that have been found to be inhumane. The new data in PLoS Medicine will further strengthen the constitutional case for the abandonment of execution in the US."

The PLoS Medicine Editors. Lethal injection is not humane. *PLoS Med* 2007; 4(4): e171; Zimmers TA, Sheldon J, Lubarsky DA, López-Muñoz F, Waterman L, et al. Lethal injection for execution: chemical asphyxiation? *PLoS Med* 2007; 4(4): e156