

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.bmjournals.com>), Canadian Medical Association Journal (www.cma.ca/cmaj.com), and Eubios Journal of Asian and International Ethics (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 May 2008 - July 2008 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.

Carbon footprints and the conference circuit

In this debate on whether professionals should hop from conference to conference, Drife argues that despite drawbacks like increasing carbon footprint due to travel, and the problems of pharmaceutical sponsorship, the conference format is valuable in highlighting important issues such as the Declaration of Helsinki, boycotting of the apartheid regime in South Africa, etc. Also interpersonal contact improves understanding of issues and inspires attendees. A compromise more acceptable to the critics might be to reduce the number of conferences and hold them in meaningful locations such as rural areas of developing countries.

Green, on the other hand, asserts that modern technology allows all the benefits of a conference without the negative environmental impact of actually attending one. Scientists can present their data to networks of peers and attend video lectures to keep up with the latest in their specialty. Current technology is so good that it gives the feeling of being actually present in the lecture room and even allows immediate interaction with the speaker. If one excludes the benefits of sightseeing at exotic places, there is really no need to have conferences.

Drife JO. Are international medical conferences an outdated luxury the planet can't afford? No. *BMJ* 2008 Jun 28;336(7659):1467. Green M. Are international medical conferences an outdated luxury the planet can't afford? Yes. *BMJ* 2008 Jun 28;336(7659):1466.

Patients information vs medical records

Hospitals often conduct a survey for patient satisfaction. This survey done to assess the incidence of adverse events, asked the patients, post discharge, if they had any adverse events during hospital stay. The same patients' hospital records were reviewed by trained nurses to detect adverse events. More events were detected in interviews than in the records. Authors suggest that focused interviews with patients post discharge may help in identifying preventable adverse events.

Weissman JS, Schneider EC, Weingart SN et al. Comparing patient-reported hospital adverse events with medical record review: do patients know something that hospitals do not? *Annals Intern Med* 2008 Jul;149(2):100-8.

Informed public participation in policy

Health care funds have to be allotted to different programmes based on priorities. Decisions on these priorities are usually made by the government with scant input from the general public. Encouraging greater public participation in these decisions will be good as the public will have greater trust

in the health system since they have been consulted in the process. Yet many feel that the lay public is not sufficiently well informed and objective to participate intelligently and that they will be intimidated by those in power and will make the process of allocation long drawn out. The authors suggest ways to overcome these hurdles and strongly advocate for greater public participation.

Bruni RA, Laupacis A, Martin DK et al. Public engagement in setting priorities in health care. *CMAJ* 2008 Jul 1;179(1): 15-8.

Internships in foreign countries - or rural areas

The author, medical director of a district hospital in Cameroon, gives useful suggestions to medical students and residents who wish to pursue an elective in Africa. She reiterates that it is really the students who will benefit enormously from the clinical experience and not the community where they are located. She gives tips about personal safety, advises students to learn about not just medicine but also the socio-cultural milieu in which they are placed, to keep up with reading about the new diseases they will encounter, etc. This extremely well written short article is appropriate even for students in India to whom rural medical settings are as foreign and incomprehensible as Africa is to students from developed countries.

Einterz EM. The medical student elective in Africa: Advice from the field. *CMAJ* 2008 May 20;178(11):1461-3.

Medical students abroad

The authors bring their personal experience to this article on the benefits and ethical pitfalls of health care experience for medical students in a resource-poor setting such as developing countries. Global health experience induces the medical practitioner to think about not just health but the social, political and cultural setting and global health disparities. Often medical students are motivated to switch from subspecialty to primary care. This awareness has led several medical schools to incorporate an exposure to this experience in their academic curriculum. The authors point out that the students may be tempted and often inadvertently end up providing care which is far beyond their expertise. To prevent such ethical missteps, they advocate a course on professionalism and preparing students to work with vulnerable populations in a resource poor setting.

Shah S, Wu T. The medical student global health experience: professionalism and ethical implications. *J Med Ethics* 2008;34(5):375-8.

sTop top talk

The author describes a scene in a hospital ward where a patient lies on the table waiting patiently while all around her the various people, doctors, nurses, students, etc are talking. They talk about her but do not address her directly and talk about events that interest them but have no relevance to her or the ongoing activity. The author has named this very common behavior "Top Talk". This behavior is not only rude but also violates the principle of patient autonomy as talking over a patient implies that the patient has no worth. The author encourages every one to put up a prominent poster "sTOP" that will draw attention of the medical staff to this ubiquitous hurtful behavior and put a sTOP to it.

Flegel K. Talking over patients: sTOP. CMAJ 2008 May 6;178(10):1388.

When drug companies pay doctors...

Senior doctors are paid generous fees to talk favourably about specific drugs by the concerned pharmaceutical company. The doctors may seem to be independent experts, but in reality they are salespeople for the company. The company often tracks the impact of their talk on the volume of prescriptions before and after the talk. If the sales pitch is not considered effective, the doctor loses future speaking assignments. Doctors are not always in the pay of the company when they speak favourably of a drug; often they may do so simply because it is a good drug. But if the company then pays them in some way, that creates a conflict of interest which undermines public trust. Therefore the practice of payments to doctors for speaking about a particular drug should be stopped.

Moynihan R. Key opinion leaders: independent experts or drug representatives in disguise? BMJ 2008 Jun 21;336(7658):1402-3.

Better reporting of clinical trials

Clinical trials must be reported to the public but often the reporting has many flaws that make the data difficult to understand. WHO recently introduced EQUATOR (Enhancing the Quality And Transparency Of health Research), an international network to address this problem. It will direct researchers to guidelines that are easy to access and understand so that their reporting of data is accurate as well as easy to comprehend.

Groves T. Enhancing the quality and transparency of health research. BMJ 2008 Jul 8; 337:a718.

Placebos but with permission

The author says that many doctors hesitate to use placebos as it involves deceiving the patient. However if the placebo has proved useful in evidence-based medicine, as in a clinical trial, then this should be related to the patient and the placebo prescribed with the patient's knowledge and consent. Most patients are interested not simply in getting better but also avoiding as many side effects as possible, and therefore would be quite willing to give the placebo treatment a trial. In order for the placebo to be used as treatment one must have a full description of the placebo used from the researcher who conducted the trial. Also, the patient should be given the results of the trial if she/he demands it.

Pittrof R. The thinking doctor's guide to placebos. BMJ 2008 May 3; 336: 1020.

Forcing treatment for obesity

The author, drawing a parallel between the anorexics and the obese, wonders why the former can be forcibly hospitalised and fed but the obese are not forced to diet. She asserts that both anorexics and obese are intelligent and could be considered as depressed and yet the anorexic is deemed incompetent while the obese is not. She asserts that there is no justification for this differential treatment.

Giordano S. Should we force the obese to diet? J Med Ethics 2008;34:319.

When a doctor needs help

This editorial comments on the findings of a survey of substance abuse among medical students (published in the same issue). Neither the Medical Council of India nor the Indian Medical Association has anything to say about this serious problem. The medical education system subjects students to stress and does not teach them how to de-stress. While some students "grow" out of such habits, others progress to more serious addictions. The writer points out that discussions on substance abuse have focused on the difficulties in carrying out professional responsibilities and the potential harm to patients. However, it is also important to think of the health consequences to the doctor, to make professional help available, and to do this in a constructive manner, with the possibility of eventually returning to work. The editorial goes on to discuss the actions taken by medical associations in the US and the UK to support doctors with impaired functioning whether due to substance abuse or mental health problems.

Seshadri S. Substance abuse among medical students and doctors: a call for action. Natl Med J India 2008; 21(2): 57-9.

Countering drug promotion practices

This article points out that doctors' prescribing practices are greatly influenced by the promotional literature of drug companies - who are concerned with promoting their product, not with educating doctors. Studies have shown that promotional practices are deceptive; medical representatives make many false statements and the majority of journal advertisements are based on studies of poor quality. However, few doctors know how to appraise promotional material, and studies have found that only one in four doctors could identify flawed studies and false statements. The authors argue that an active approach by doctors can transform promotional literature into a useful and accurate source of information. They provide a set of questions that doctors must ask when reading such literature.

"The new drug should be relevant to the clinician's practice in terms of population studied, the disease and the need for new treatment. The methodology of the study should be carefully judged to determine the authenticity of the evidence. The new drug should be preferred over the existing one only if it offers clear advantages in terms of safety, tolerability, efficacy and price."

Shetty VV, Karve AV. Promotional literature: How do we critically appraise? *J Postgrad Med* 2008;54:217-21

Caring for a dying child

Children with advanced terminal illnesses have needs that may be different from adults' but paediatric palliative care is an underdeveloped specialty. This study in a tertiary care centre for cancer interviewed parents of paediatric palliative care patients in out-patient departments. Some of the findings: Parents showed varying degrees of anticipatory grief. Most families were under financial stress. Most parents were reluctant to discuss disease and dying with their children. Siblings were rarely told or involved in the care of the terminally ill child. There was resistance in letting the palliative care team communicate directly with the patient. Patients did not receive any formal support.

The authors conclude that there is a need for research to understand the concerns of families in this situation, and professionals need special training for paediatric palliative care.

Dighe M, Jadhav S, Muckaden MA, Sovani A. Parental concerns in children requiring palliative care. *Indian J Palliative Care* 2008; 14(1): 16-22.

A community-based palliative care policy

This article describes the palliative care policy of the government of Kerala: the first by any government in Asia, emphasising the community-based, home-based approach,

and highlighting the need to integrate palliative care with primary health care services. This policy was announced in April 2008. The emphasis is on training professionals, setting up services in the public sector and community, and making essential drugs like morphine available for palliative care. The policy can be downloaded from a number of websites, including www.palliativecare.in, the website of the Indian Association of Palliative Care.

Palleri AK. Showing the way forward: pain and palliative care policy of the government of Kerala. *Indian J Palliative Care* 2008; 14(1): 51-4.

Transparency in clinical trial reporting

The requirements of the International Council of Medical Journal Editors (ICMJE) have set standards that promote clarity as well as transparency in reporting clinical trials. To what extent have these international guidelines been adopted by Indian medical journals? This survey of 65 Indian journals found though 38 mentioned the ICMJE requirements in their guidelines for authors, many of the published articles did not meet these guidelines, affecting the quality of the report. Further, ethical issues were poorly reported in one-third of reports, and sources of funding and conflicts of interest were not declared in over three-fourths of reports.

Tharyan P, Premkumar TS, Mathew V, Barnabas JP, Manuelraj. Editorial policy and the reporting of randomized controlled trials: a survey of instructions for authors and assessment of trial reports in Indian medical journals (2004-05). *Natl Med J India* 2008; 21(2): 62-8.

Technology in health care: current controversies

Editors: Sandhya Srinivasan, George Thomas

Published by: Forum for Medical Ethics Society and Centre for Studies in Ethics and Rights, Mumbai. December 2007. 288 pages. Rs 200

This collection of essays covers important discussions related to medical technology that have been carried in the Indian Journal of Medical Ethics. Each of the nine sections is preceded by a commentary by an expert in the field. The nine chapters cover placebo controls in research; intellectual property rights; family planning and population control; the HIV/AIDS programme and research; electro convulsive therapy without anaesthesia, liver transplant technologies, end-of-life care, medical professionals and law enforcement, and technology in public health programmes.

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