

similar groups.

Funds and secretarial help are mandatory for the proper functioning of such a committee.

The entire institution must want and welcome the formation of such a committee, seeing it as a means for improving standards, providing better care to patients and carrying out research of the highest standards.

Poor selection of members on the committee: If these individuals are already short of time, it is unlikely that they will pay much attention to the tasks to be attended to on behalf of the committee. cursory inspection of documents, little or no follow up action and frequent absences from meetings of the committee are expected consequences.

The members must possess a strong motivation for im-

proving the conditions under which patients are treated and research practiced. They should have already devoted some time and energy in identifying current slip-ups and malpractice and the means to be employed in correcting them.

They must also be conversant with current trends in national and international biomedical ethics. Without continued self-education, they are likely to lapse into rigidity of approach and dogmatic decisions.

References

1. Pilgaokar, Anil: Ethics in biomedical research. Unpublished paper presented at annual meeting of the Medico Friend Circle, 1995.
2. Silverman Henry J: Revitalizing a hospital ethics committee. *HEC Forum* 1994;6: 189-222.

FROM OTHER JOURNALS

*All's not well with clinical trials*¹

Research by US epidemiologist Kenneth Schulz and colleagues shows that a considerable number of doctors involved in clinical trials cheat by interfering with the randomness of clinical trials by ransacking private offices, cracking secret codes and probing contents of secret envelopes. Some may do so in order to ensure that their patients get the best treatment but, in attempting to fulfil their obligations to the patient, they vitiate their roles as medical researchers, skew results and invalidate the trial.

Doubt has been expressed by Samuel Hellman on whether a clinician can simultaneously fulfil the dual roles of doctor and researcher. The fundamental divergence between the clinician wishing to do his best for the individual patient and the researcher whose primary interest lies in collecting groups of patients suggests that Hellman's essay (pages 5- 10 of the special supplement in this issue) deserves study.

The interested reader will also find much of interest on pages 1-16 of the special supplement on Ethics Committees.

*Voluntary euthanasia*²

Independent legislator, Michael Moore, introduced his Medical Treatment (Amendment) Bill 1995 into the Legislative Assembly of the Australian Capital Territory, seeking to allow doctors to provide direct help in dying to terminally ill patients who requested it. The bill was defeated on 22 November with two rebel members of parliament cross-

ing the floor to vote with the Liberal Party.

In the state of Victoria, doctors petitioned the government for a review of laws prohibiting voluntary euthanasia. This appeal was rejected.

In the Northern Territory it is expected that any day now the Rights of the terminally ill bill will be gazetted and become operational. Patients with severe pain from advanced cancer are already travelling from other states to see direct, immediate help in dying under this law. 70 year old Marta Alfonso-Bowes, who had reached Darwin and sought a lethal injection was dejected when she found that the law was not yet in operation. After a failed attempt at suicide, she succeeded in taking her own life on 24 September after taking an overdose of tablets.

The following news item in this journal describes how seven doctors have joined Dr. Jack Kevorkian in unveiling guidelines for medically assisted suicide in the USA. The group feels that patients and doctors and not politicians or courts should determine when incurable patients should be helped to die. The guidelines call for a written request from the patient, signed by a doctor and two adults with no financial interest in the case. A specialist in the patient's illness, one on the management of pain and a psychiatrist will have to verify in writing that the patient was mentally competent, suffered from an incurable disease and had uncontrollable suffering.

The journal also refers to a paper in the Journal of the American Medical Association (1995;274:1634- 1626) where a long term study costing twenty-eight million US dollars showed that many patients die under cold and painful circumstances. The study also shows that dying patients often fail to make their wishes known and when they do, encounter indifference by doctors to their request to be spared life-sustaining treatment.

*Care of dying patients in hospital*³

This paper describes a prospective study of 50 dying patients in 13 wards in four large teaching hospitals in the west of Scotland. The opening sentence grabs attention. 'Though most terminally ill patients indicate a preference to die at home, . . . more than 60% of all death (over the past two decades) occurred in an institution.' The conclusion is equally riveting. 'Care of many of the dying patients observed in these hospitals was poor. We need to identify and implement practical steps to facilitate high quality care of the dying. Much can be learned from the hospice movement...'

References

1. Kuhse Helga: Clinical trials. *Monash Bioethics Review* 1996; 5:1-2
2. Anonymous: Voluntary euthanasia - Australia. News in brief. *Monash Bioethics Review* 1996;15:3-4
3. Mills Mina, Davies Huw TO, Macrae William A: Care of dying patients in hospital. *Monash Bioethics Review* 1996;15:11-19