

### Learning on a dying patient

■ “A hospitalised patient has been receiving cardio-pulmonary resuscitation for 20 minutes without any success, and is unlikely to survive the resuscitation attempt. Is it appropriate for a house officer to insert a femoral venous line for practice?”

Thirty-four percent of the 238 house officers in a US teaching hospital who were asked this question felt it was sometimes appropriate to do this unnecessary and invasive procedure for the resident to get experience. Twenty-six per cent had seen someone else do it; 16 per cent had done it themselves.

The authors describe a problem faced by teaching hospitals: service provision must be combined with learning, including invasive procedures which can harm patients when performed by novices. Many procedures are taught on animals and models. Some are taught using bodies of recently-deceased patients, and on live patients. The latter cases need informed consent from the next of kin.

The authors point out that the tension between patients' and students' interests is lessened when trainees are adequately supervised, when patients give informed consent, and when only medically indicated procedures are performed. “Inserting a femoral-vein catheter for practice in a person undergoing CPR when the procedure is not medically indicated or when informed consent has not been given is inconsistent with current standards of medical ethics based on principles of beneficence, nonmaleficence, and respect for patients' autonomy.”

“Training programs should consider how aspects of clinical education may unintentionally reinforce attitudes that can reduce patients to mere objects of use in education.”

**Kaldjian LC et al: Insertion of femoral-vein catheters for practice by medical house officers during cardiopulmonary resuscitation *The New England Journal of Medicine* 1999; 341 (27)**

### Transplants for people with Down's Syndrome

■ This is of relevance to Indian

doctors facing similar ethical dilemmas treating people with disabilities which could limit understanding of and compliance to treatment.

Though 40 per cent of people with Down's Syndrome have congenital heart disease, and in the UK, many are potential candidates for heart transplants or heart-lung transplants, the authors report that in 14 years of practice with over 800 transplants, they received only one referral for a patient with Down's syndrome. A questionnaire sent to other UK transplant centres revealed only two other referrals.

The perceptions: a transplant is “too much” for someone with Down's syndrome, or the patient will be difficult to manage. Coexisting medical problems may be contraindications to transplantation, and various possible complications make the decision even more complex.

Respondents also said that patients' ability to understand the transplant process would influence the decision to accept them, though case reports of renal transplants in Down's syndrome and assessment of children undergoing bone marrow transplants report no problems with compliance.

Transplant specialists and the public may be uncomfortable about allocating limited donor organs to patients with Down's syndrome, especially if they are considered “high risk” transplants. On the other hand, people with Down's syndrome may receive suboptimal medical care.

**Leonard Helen et al: Heart and heart-lung transplantation in Down's syndrome: The lack of supportive evidence means each case must be carefully assessed *BMJ* 2000; 320: 816-817**

### Tubal nutrition for patients with dementia

■ One of the most difficult decisions relatives and doctors must make about medical care for patients with dementia concerns artificial nutrition and hydration. Family members cannot stand the thought of letting a loved one “starve to death.” Doctors don't know much about the ethical or legal issues involved – or they are unconvinced by

their arguments. It is often not known what the person would want, and it is felt that feeding through a tube will extend life, prevent aspiration pneumonia, and prevent suffering. Also, there is the feeling that nutrition should never be withheld.

The author cites various studies to argue that there is no evidence that tube feeding prevents suffering or prolongs life. Patients with dementia tend to pull out tubes, which means they have to be restrained, which is distressing. Tubes don't necessarily prevent aspiration or extend the person's life. Nor are hunger and thirst major issues for people with advanced dementia. Finally, both the Roman Catholic and the Orthodox Jewish traditions reject the use of interventions which cause or prolong suffering. The author suggests that gastrostomy tubes not be used routinely in patients with advanced dementia, unless a family member requests it because they believe the patient would have wanted it.

**Gillick MR: Rethinking the role of tube feeding in patients with advanced dementia *The New England Journal of Medicine* 2000; 342 (3)**

### Are US resident doctors employees, not students?

■ The US National Labor Relations Board's recent ruling that resident doctors are employees under the provisions of the National Labor Relations Act provoked an exchange in the *NEJM*. Jordan Cohen argues that residents are basically students who provide services as part of their education and get a stipend for living expenses during their training. Yes, residents' working conditions have been affected by the many and widespread changes in medical care: “attending physicians have less time for teaching; fewer ancillary personnel are available to assist with patient care; opportunities for contemplation and study have dwindled; and the institutional commitment to education is often obscured by a preoccupation with economic survival.” However, the adversarial character of labour-management relations is irreconcilable with the bond of trust that must exist between teacher and student, doctor



and patient. Residents must use existing avenues of grievance redressal. Teaching hospitals must also convince their resident staff that their institutions do listen and respond to their concerns.

**Cohen JJ: White coats should not have union labels** *The New England Journal of Medicine* 2000 February 10; 342 (6)

■ The NLRB's ruling is justified by Andrew Yacht who traces the history of the decision and points out that public hospitals have long been allowed to form unions; the latest ruling will give more than 50,000 residents in private hospitals in the US the right to form unions.

In the current climate of "sweeping federal cuts in health care funding, widespread hospital mergers, and local budgetary constraints", residents are used to routinely provide basic services necessary for patient care. Collective bargaining will enable residents to focus on skills of long-term value. There is no reason to believe that the decision will interfere with the time-honoured relationship between teacher and learner. Regular negotiations and legally enforceable, collectively bargained agreements may actually prevent strikes. They provide channels of communication for the resolution of problems before a crisis is reached.

"With the strength and privilege of collective bargaining, however, comes collective responsibility... No action... should ever be taken without full comprehension of potential short- and long-term consequences for our patients and our profession. Unions of residents must continue to reflect residents' professionalism and dedication."

**Yacht AC: Collective bargaining is the right step** *The New England Journal of Medicine* 2000 February 10; 342 (6)

## Research ethics in developing countries

■ This editorial comments on a study in the journal, looking at the role of antibiotics in reducing the prevalence of sexually transmitted diseases and the incidence of HIV. Everyone in five of 10 Ugandan villages was given antibiotics to reduce STDs; everyone in all 10 villages

submitted to detailed medical and sexual histories, as well as periodic lab tests for STDs and HIV. The researchers found that antibiotics reduced the prevalence of other STDs, but not the incidence of HIV-1. HIV transmission in HIV-discordant couples was associated with the viral load of the HIV positive partner.

To get this information, several hundred people with HIV infection were observed but not treated. Nor did investigators ensure that HIV-positive people informed their partners. In the five 'treated' villages, people found to have STDs were given antibiotics; in the 'untreated' villages, they were referred to free government clinics.

"Such a study could not have been performed in the United States, where it would be expected that patients with HIV and other sexually transmitted diseases would be treated. In addition, in most states it would be expected that caregivers would see that seronegative partners were informed of their special risk," writes the author.

The researchers' reasons: participants were not being deprived of drugs that they would normally receive. Also, it was the Ugandan government's policy not to inform the partners of HIV positive people. "Many studies in developing countries now use a similar rationale for observing subjects for outcomes that could be prevented."

The author points out that proponents of such research defend it on the grounds that it is relevant to the conditions of the research population. But does information from such studies benefit the participating population? "As is so often the case, the results will probably find their greatest application in the developed world."

The author explains why she chose to publish what she feels is an unethical study: It had been approved by ethics committees in Uganda, the participating universities and the National Institutes of Health. The subjects were reported to have given oral informed consent (though it is difficult to say how clearly the study was explained to them). It was also approved by peer reviewers and the journal's staff. When two ethicists were asked for their opinions, "One thought the study was not ethical; the other

thought it was." Hence the decision to publish, and invite further discussion on what is obviously a very complex issue. "What is important is that the issues be explored honestly, not defensively, and that the answers reflect moral reasoning, rather than simply expediency."

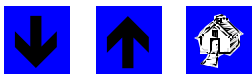
Angell Marcia: Investigators' responsibilities for human subjects in developing countries *The New England Journal of Medicine* 2000; 342 (13) Referring to: Quinn Thomas C et al for the Rakai Project Study Group: Viral load and heterosexual transmission of Human Immunodeficiency Virus Type 1; *NEJM* 2000; 342: 921-9.

## We'd rather be sponsored..

■ The Bangalore branch of the Indian Academy of Pediatrics conducted a survey on its practice of funding its continuing medical education programmes through pharmaceutical sponsorship to pay for out-of-town speakers, accommodation, a hall, food and hand-outs, and to subsidise post-graduate students. "With the fierce competition, tighter budgets, increasing costs and with the increase in the number of CMEs organized every year, the pharmaceutical companies have become more demanding", trying to control the subject of the CME.

Of 170 delegates registered for the programme, 137 handed in their questionnaires (most were post-graduate students, then practicing paediatricians, and teachers), and of these only 46.7 per cent responded completely. Eighty-seven per cent were in favour of pharmaceutical companies sponsoring CMEs. Eighty-five per cent said Rs 1,000 was too much to charge for a two-day CME; Rs 200-300 was okay for almost 70 per cent (the authors estimate that the most modest meeting would cost a minimum of Rs 625 per person). Nor did the respondents like the idea of contributing towards a corpus fund to fund CMEs, or not having outside speakers.

**Jain Mukta M et al: Questionnaire survey on sponsorship of continuing medical education program by pharmaceutical companies.** *Indian Pediatrics* 2000; 37: 190-92.



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**CALENDAR: April-June 20, 2000**

**June 20-24, 2000, Gijon, Spain:** 'A World Wide Society for the Century of Bioethics.' World conference on bioethics. Contact the congress technical secretariat at C/ Maternidad 2, 332007, Gijon - Espana

Tel: 34 985 17 60 06.

Fax: 34 985 17 55 07.

E-mail: [Congresso@sibi.org](mailto:Congresso@sibi.org).

Website: [www.biotica.sibi.org](http://www.biotica.sibi.org)

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**July 5-9 2000, Sydney, Australia:** 'Voices and silences of bioethics' (Australian Bioethics Association) and 'Boundary disputes: ethics, law and regulation -- the limits of the law' (Australian Institute of Health, Law and Ethics).

Tel: 61 02 9439 6744.

Fax: 61 02 9439 2504.

E-mail: [dccon@tmx.com.au](mailto:dccon@tmx.com.au).

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**September 21-24, 2000, London, UK:** 'Ethics, law and public policy'. Fifth World Congress of Bioethics. Contact the Congress office: In any Event UK, 1 Riverside, St Anne's Road, Bristol, BS4 4ED.

Email: [enquiries@inanyevent-uk.com](mailto:enquiries@inanyevent-uk.com).

Website: [www.uclan.ac.uk/facs/ethics/fifthcon.htm](http://www.uclan.ac.uk/facs/ethics/fifthcon.htm).

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**November 5-9, 2000, Beer Sheva, Israel:** 'Ethics across cultures, eras and borders.' Eighth International Congress on Ethics in Medicine. Contact the Congress Secretariat, Peltours-Te'um Congress Organisers, POB 52047, Jerusalem 91520, Israel.

Tel: 972 2 648 1245.

Fax: 972 2 648 1305.

E-mail: [teumcong@netmedia.net.il](mailto:teumcong@netmedia.net.il).

Website: [www.teumcong.co.il](http://www.teumcong.co.il).

Website on health law and ethics

**A new website was launched in Bangalore on January 15.**

**[www.healthlawindia.com](http://www.healthlawindia.com)**

- facilitates a closer interface between medicos and those in the legal profession,
- caters to the information and strategic needs of the stakeholders in the healthcare arena,
- provides room for the inter professional discourse and deliberations on issues falling with the broad purview of health law and ethics apart from pointing out various aspects that strike a balance between professional autonomy and patient satisfaction,
- facilitates dissemination of healthcare related issues in the backdrop of social, economic, political and developmental context and
- provides information on healthcare facets, legal and judicial decisions, book reviews, online consultancy and calender of events.

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## Call for contributions

*Issues in Medical Ethics* depends on contributions from its readers for its growth as a journal provoking discussion and debate on a range of subjects to do with health and medical ethics. The 'Discussion' sections in the next four issues are being listed below in order to encourage contributions from readers on these topics.

The final edited version of contributions should be 1,600 words including references. Contributions (by post to our postal address, or by e-mail to [sandhya@bom3.vsnl.net.in](mailto:sandhya@bom3.vsnl.net.in)) should reach us by the third week of May, August, November and February for the July, October, January and April issues, respectively. Please see the inside front cover for further details on the format.

July-September 2000: Diabetes

October-December 2000: Public health

January-March 2001: Private insurance

April-June 2001: Transplantation

