

Review of medical ethics

■ This review identifies significant issues, events and documents in discussions medical ethics relating to end of life care, medical error, priority setting, biotechnology, and medical ethics education, and anticipates two future issues, "eHealth" and global bioethics. For example, regarding medical error, the US Institute of Medicine's 1999 report on medical error and the Tavistock Group's draft statement of "Shared ethical principles for everybody in health care" provide a foundation for discussion. Reports by the US National Bioethics Advisory Commission and the UK Nuffield Council on Bioethics, are the latest in a series of important consensus documents on biotechnology. In the area of medical ethics education, two developments are the General Medical Council's requirement that medical ethics be a core subject in the medical curriculum, and the Royal College of Physicians and Surgeons of Canada requirement that medical ethics be taught as a condition of post-graduate accreditation.

As for future issues: the code of ethics for 'eHealth' addresses ethical issues raised by the information technology revolution. And in the area of global bioethics, there is the International Association of Bioethics and a discussion board on global bioethics.

Singer PA: Recent advances in medical ethics *BMJ* 2000; 321: 282-285

Unlinked testing: informing the public

■ Unlinked anonymous testing for HIV has been used as a monitoring tool in many countries. This UK survey on the public's view's on the practice, both for HIV (where it has been carried out since 1989) and for other diseases, found that less than one-third of those interviewed were aware of the practice, and a little over 26 per cent disagreed with its use for HIV or for other diseases; opposition was highest among those unaware of the policy. The author suggests a reconsideration of the current policy. The epidemic has not materialised as expected in the UK, the balance between the social usefulness of the programme and the

individual's right to determine what happens to his or her blood has changed. All patients should know of the policy and the option of opting out.

In response to letters on this article, the authors emphasise that the issue is: under what conditions is it acceptable not to let people (explicitly) know what is happening with their tissue samples? Lack of openness could damage the relationship between patients and health care workers.

This discussion may seem esoteric to us in India, where linked, involuntary testing for HIV is routinely done on in-patients in private and public hospitals, and patients who test positive are refused treatment.

Kessel A et al: Bad blood? Survey of public's views on unlinked anonymous testing of blood for HIV and other diseases. *BMJ* 2000 320: 90-91.

Cheating in medical school

■ The editor of the *BMJ* reports on a complaint that a top student in the UK caught referring to a clinical textbook during her exam was allowed to pass her exams though honours she would have received were withheld. This triggered off resentment among other students, and the complaint to the *BMJ*. The editor argues that the student's actions cast doubt on her work in general. Also, the authorities' actions send the wrong message to other students, and undermine medical education and medicine.

The flood of letters on this editorial express the full range of opinions, from supporting the editor for his commitment to medical ethics to attacking him for tarnishing the profession's good name, to questioning the examination system itself. Three writers trained in India are interesting for their perspective. One is shocked that cheating was condoned by the British. Another makes a connection to the prevalence of cheating in medical schools in India. "Money plays a huge part not only in the admission process, but also in the progress through examinations... Of course there are upright, honest and decent people- but sadly they are not the majority." Yet another comments:

"I trained at a large state-run medical school in south India, and it did not take an editorial in a major medical journal to make us aware that cheating amongst medical students does occur. Most instances are dealt with sternly, but sensibly and no, we do not quote "British standards" when we do."

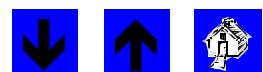
Smith R: Cheating at medical school Justice must be done and seen to be done *BMJ* 2000;321:398 (12 August) and responses by V Ramaprasad, August 13 and P Prabhakar August 18. M Thambisetty, August 19.

When there is no hope

■ Heated debate on the concept of medical futility in the late 1980s produced a number of theories of action before receding into the background by the early 1990s.. At its basis was the idea that once doctors judged the futility of a treatment they should be allowed to withhold treatment even over the patient's objections. The debate was fuelled by policies such as brain death definitions gave hope a similar policy for futility, technological advances for prolonging life, and health financing raised issues of cost. However, the issue has not been adequately resolved.

Discussions of futility can be grouped into four categories: attempts to define medical futility, attempts to resolve the debate with the use of empirical data, discussions that cast the debate as a struggle between the autonomy of patients and the autonomy of physicians, and attempts to develop a process for resolving disputes over futility.

The authors seem to conclude that the most productive approach has been to develop frameworks within which physicians can discuss with patients and their families the possibility that treatment would be futile. The process involves assessing the goals of the physician, patient, and family; clarifying information and beginning to negotiate; acknowledging differences in values; and arriving at a compromise, sometimes with the help of ethics committees or the courts. This approach led to the development of hospital and regional policies for resolving conflicts over futility.



Helft PR et al: The Rise and fall of the Futility Movement *The New England Journal of Medicine* 2000; 343(4).

The magic drug

■ The project to map the human genome has created a wave of optimism about the future of gene therapy. The authors are less exuberant. The new genetics will not revolutionise the way in which common diseases are identified or prevented. Though mapping and sequencing the human genome will lead to the identification of more genes causing mendelian disorders such as Huntington's Disease, and to the development of diagnostic and predictive tests for them, this won't necessarily lead to the swift development of safe and effective treatments.

More important, only a small proportion of the population has mendelian disorders. It has not been possible so far to find a strong genetic link for asthma, hypertension, and so on. Even where a link has been found for breast cancer, or Alzheimer's disease, the gene accounts for a small percentage of all cases.

Tailoring treatment to genotypes sounds better than it is possible or useful. And the value of testing depends on the test, the prevalence of the condition, the availability of effective treatment, and the value the public sees in it all.

The authors write: "In our rush to fit medicine with the genetic mantle, we are losing sight of other possibilities for improving the public health... Differences in social structure, lifestyle, and environment account for much larger proportions of disease than genetic differences... Those who make medical and science policies in the next decade would do well to see beyond the hype."

Holtzman NA and Marteau TM: Will genetics revolutionize medicine? Sounding board *The New England Journal of Medicine* 2000; Vol. 343 (2)

Altruistic organ donation

■ The authors discuss the basis of their centre's policy on "non-directed donation": donation of a kidney to anyone on the waiting list for a

cadaveric organ. The policy covers evaluation of donors to assess their competence to make an informed decision; selection of recipients; evaluation of recipients; interval between evaluation and surgery to allow the donor to reconsider; special considerations such as different requirements of the donor, recipient and transplant group; and long-term follow-up. Four such transplants have been carried out since the policy was instituted.

The authors note that the policy raises two major ethical questions: is the transplantation of organs from living donors is ethically justified and, if so, under what conditions? Better survival rates with living donors, long waits for a cadaveric kidney, and psychological benefits to the donor must be weighed against the physical risks to the donor. Second, is the balance between risks and benefits altered in non-directed donations by the element of altruism?

They argue that such donors are not under any pressure; donors are known to experience increased self-esteem, the risk of morbidity is low, and their health is similar to or better than that of the general population.

The authors describe the process of allocating organs as based on an attempt to balance two potentially competing objectives: maximising the probability of a successful outcome and making allocation equitable. Hence potential recipients were limited to patients in need of a first or second transplant, excluding those with a history of noncompliance with medical regimens, and the transplantation had to be performed at our institution.

Matas AJ et al: Nondirected donation of kidneys from living donors *The New England Journal of Medicine* 2000; Vol. 343 (6)

Insurance for whom?

■ Will the entry of the private sector into the insurance industry bring better health care for Indians? The author suggests that this is not likely, at least not in the short run. It does not guarantee that people will be protected financially, or in terms of better health. Internationally, private insurance has

not worked without proper regulation. The regulatory structure described in the Insurance Regulatory and Authority (IRDA) Bill is not enough.

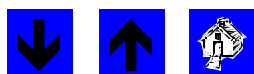
Even 10 years after the government introduced health insurance, barely 0.2% of the population was covered by its policies. Private insurance schemes will not make a dramatic overall difference to this percentage, and even this will be concentrated in urban areas. Second, insurance tends to increase health expenditures without necessarily improving the quality of care — and there are no serious efforts to regulate the private health sector. At the same time, the insurance company will try to keep costs down even if it means depriving the person of care. Finally, private insurance will not address the question of economic inequity — whether it is making the poor pay beyond their means for insurance or for out-of-pocket expenses, or whether it is reducing access to those most likely to get sick.

Mahal A: Private entry into health insurance: what does it mean for India? *The National Medical Journal of India* 2000; 13(1): 3-5.

From the inside, looking out

■ This issue of the *Hastings Center Report* carries a series of essays looking at frailties within the doctor-patient relationship. In addition to looking at the change over time from a benevolent 'dictatorship', the topics discussed examine the tendency of providers to blame their patients for the disease, special problems when the patient is from another culture and speaks another language, or how the doctor should fulfil her responsibilities in the patient's best interests when the patient expresses racist views. Finally, an essay by a medical researcher describes the special problems of truly respecting the interests of patients in phase I (toxicity) clinical trials for cancer drugs, in which the drugs are unlikely to be therapeutic, but in which some patients may receive toxic doses. Individual essays will be discussed in the next issue of *IME*.

Doctors' dilemmas: treating patients with compassion. *The Hastings Center Report* 2000; 30 (4).



Ethics and health care on the internet

The Euro Eslav project on ethical, legal and social issue in new vaccine research and vaccination policies (<http://www.euroelsav.net>), funded by the European Union, has its final conference in Rome, on November 24-25, 2000. Among the subjects addressed will be: "Policies for vaccine development: research priorities, financial mechanisms and ethical implications", taking into account issues regarding research on vaccines addressing tropical diseases in developing countries, and research on vaccines for non-infectious diseases such as Alzheimer disease and cancer in developed countries.

Tutorials

Mentoring is a powerful way for people to learn personal and professional skills. Mentors provide valuable guidance and advice by listening and helping students reflect on personal and professional issues. A collaborative effort of the Institute for Ethics and Medical Student JAMA, the Virtual Mentor (at <http://www.ama-assn.org/ethic/virtual.htm>) is an interactive, Web-based forum for analysis and discussion of clinical and professional issues that medical students encounter during their educational training. To guide students

through the process of ethical reasoning and to acquaint them with case law, a new case study will appear every two to four weeks. Students will be given legal and/or ethical opinions to assist their decision-making and are invited to join email discussions of each case.

An interactive site providing exercises in medical ethics and communication skills is MedEthEx Online, at: <http://griffin.auhs.edu/dept/medethic/intro.html>

Meetings

Panchgani (Maharashtra), December 26, 2000 - January 1, 2001:

A national conference on human rights, social movements, globalisation and the law will include two days of discussion on health. The meetings on December 30 and 31 will cover the right to health care, medical ethics, mental health, forensic medicine and human rights, violence against women and the health professional, and population and reproductive rights. For more details on participation, contact Sumita or Anagha at CEHAT, 2nd Floor, BMC Building, 135 Military Road, Marol, Andheri East, Mumbai 400 059. Email: cehat@vsnl.com. For other workshops at the conference contact the India Centre for Human Rights and Law, 4th floor, CVOD Jain School, 84 Samuel Street, Dongri, Mumbai 400 009. Email: huright@vsnl.com

Costly medical mistakes

The US Institute of Medicine's November 1999 report, *To Err is Human*, revealed that preventable medical errors caused 44,000 to 98,000 deaths annually in the US — more than the number from automobile accidents, cancer or AIDS. The cost, besides lives lost and increased illness — US \$37 billion and further degradation of people's trust in the system.

Some of the IOM's recommendations: the creation of a centre for patient safety, a national compulsory medical error reporting system, central and state laws encouraging voluntary error reporting systems, and more focus on patient safety and the safe use of drugs, by professional medical organisations.

Any guesses about the Indian situation?

People

The Maharashtra Network for Positive People (MNP+)

has recently formed a separate Women's Forum to cater to women's very specific needs and vulnerabilities. They can be contacted at : mnpt@bom8.vsnl.net.in

To subscribe to the Ethical Issues in International Health Research Discussion List, sponsored by the Harvard School of Public Health, go to www.hsph.harvard.edu/bioethics.

