FROM OTHER JOURNALS

The following journals are scanned routinely for articles of interest to the medical ethics community: Annals of Internal Medicine (www.annals.org), New England Journal of Medicine (www.nejm.org), Journal of the American Medical Association (www.jama.ama-assn.org), Lancet (www.thelancet.com), The British Medical Journal (www.bmj.com), Canadian Medical Association Journal (www.cma.ca/cmaj), and The Eubios Journal of Asian and International Bioethics (www.biol/tsukuba.ac). For this issue of IME, we reviewed the Aug-Oct 2002 issues of these journals. Articles of interest from hard copies of other publications including the National Medical Journal of India, Monash Bioethics Review, and Developing World Bioethics are abstracted as and when they become available.

If you come across an article you feel should be included, please forward it to mmamdani@attbi.com

Science, belief, and ethical practice

Medical practice based on evidence is said to be the most ethical. But doctors may have to deal with the opposing demands of conviction in unproven but widely used techniques. The pulmonary artery catheter is "the mainstay of haemodynamic monitoring and management of critically ill patients", but there is evidence suggesting it is of questionable benefit, even harmful. Now, a trial of this catheter on 6,000 patients will involve the intensive care community as a whole, with ICUs all over the UK.In such a situation, there will be doctors whose patients are randomised not to receive a pulmonary artery catheter, but who believe that the catheter would be a better option. She must continually remind herself that her existing beliefs are not supported by strong scientific evidence... The writer describes this as "the perfect example of commitment to greater scrutiny and optimisation of practice that we must all engage in, across all fields of medicine".

Angus Derek, Black Nick. Editorials Wider lessons of the pulmonary artery catheter trial Intensivists are rising to the challenge of evaluating established practices. *BMJ* 2001; 322: 446.

The larger picture

"Every element of a research ethics review—the balance of risks and benefits, the assurance of rights for individual participants, and the fair selection of research populations—can be affected by the political and human rights background in which a study is done." However, this context is not routinely considered in the ethics review process. The authors provide suggestions on how such a perspective will help review boards in the decision-making process.

Kass Nancy E, Beyrer Chris Human rights, politics, and reviews of research ethics. *Lancet* 2002; 360: 246-51.

New research guidelines

The American Institute of Medicine has issued new guidelines for protecting human research subjects. It calls for improving informed consent practices. The IOM report is available at http://www.iom.edu.

Vastag, B. New Focus on Research Participant Protection. *JAMA* 2002;288 (16):1973.

Support the freedom to publish

The authors describe a dispute between a researcher and the manufacturer of a drug. When the researcher insisted on publishing her data considered adverse by the manufacturer, she had to face legal harassment from the company and got no assistance from her hospital or the university. The authors are firm in siding with the researcher and suggest ways that such conflicts could be handled in the future.

Nathan, DG and Weatherall, DJ. Academic Freedom in Clinical Research. *N Engl J Med* 2002; 347(17):1368-1371.

The industry's influence

The relationships between academic institutions and private companies are increasing with faculty members and universities having increasingly strong financial and non-financial incentives to participate directly in the development of drugs, devices, and diagnostic tests. Many negative implications of this trend have been recognised. The authors outline seven areas in which critical choices are to be made and discuss how to face them.

Moses, H et al. Collaborating with industry - choices for the academic medical center. *N Engl J Med* 2002;347(17):1371-1375.

Working with the private sector

Cooperation between academic institutions and the private sector does not always run smoothly. The authors point up the need for guidance on entering into partnership with a commercial partner and describe their institution's experience in formulating guidelines for its staff.

Walt, G et al. Working with the private sector: the need for institutional guidelines. *BMJ* 2002; 325(7361): 432-435.

Researchers must document ethical issues

Clinical investigators rarely describe the rationale for ethically controversial features of study design, or procedures instituted to enhance the protection of the subjects, or how they ensured informed consent. To promote public accountability, the article recommends a policy of extensive reporting of pertinent ethical issues.

Miller FJ, Rosenstein DL. Reporting of ethical issues in publications of medical research. *Lancet* 2002; 360: 1326-28.

Strengthen ethics committees

Research involving humans is subject to codes of ethical conduct that mandate review, approval, and monitoring of clinical trials by research ethics committees (RECs). Article recommends RECs should have a prominent role in ensuring that trial results are publicly disseminated and proposes specific responsibilities for the funders, host institutions, and consumers.

Mann H. Research ethics committees and public dissemination of clinical trial results. *Lancet* 2002; 360: 406-08.

The scientific-clinical interface

While ethics is discussed as it pertains to clinical research, there is a need for such discussion in basic science research, because both are increasingly intertwined as in stem cell

research. As potential financial rewards or fame beckon, it is difficult to instil sound moral thinking in researchers.

Mitka M. Emphasis on ethics increases at basic and clinical research interface. *JAMA* 2002; 288 (13): 1577.

Non-financial conflicts

Increasing attention has been paid to financial conflicts of interest in research. Non-financial conflicts of interest on the part of investigators and institutions are just as important. Investigators are motivated by desire to advance knowledge, prestige, and career advancement. Institutions wish to enhance their reputation as research centres. These interests cannot be eliminated but need to be managed appropriately.

Levinsky N G. Nonfinancial conflicts of interest. *N Engl J Med* 2002; 347(10): 759-761.

Tired doctors are dangerous

Sleep deprivation due to extended work hours leads to fatigue which impairs human performance. In this article, the authors discuss current and proposed policies concerning clinicians' work hours and fatigue. A comprehensive strategy to reduce fatigue is recommended.

Gaba DM and Howard SK. Fatigue among clinicians and the safety of patients. *N Engl J Med* 2002; 347(16): 1249-1255.

Ethics in health policy

To address the problem of inequality in health care, the authors recommend that policy makers must determine which inequalities lead to inequitable outcomes and assess cost-effectiveness of interventions. Ethics and social science, rather than agenda setting and lobbying, should take centre stage in this international policy debate.

Oliver A, Healey A, Le Grand J. Addressing health inequalities. *Lancet* 2002; 360: 565-67.

Dangerous NGOs

The author describes working in a remote rural clinic in Nepal and struggling with outdated or very high cost medicines donated by NGOs. As there was an established culture of belief that Western is best, he had to be extra careful to teach good medical practice which was sympathetic to the local customs. He says that though NGOs fulfil a valuable role, their charitable status should be removed if they persist in dangerous practices.

Woolrich-Burt L. First do no harm: does the Hippocratic Oath extend to developing countries? *BMJ* 2002; 325(7367):783.

More than just skill

When it comes to doctoring, the term "good" increasingly functions as a descriptive label that denotes having met certain tests of competency. A poor doctor is generally credited with good intentions but inadequate knowledge or skills required for the job. A bad doctor, however skilled, is one with bad intentions, undesirable values, suspect, occasionally evil, motives. Judging someone a bad doctor implies serious defects of moral agency, even though these may coexist with commendable aspects of medical practice. To become good doctors, medical education should teach reflection and sensitivity along with skills.

Hurwitz B and Vass A. What's a good doctor, and how can you make one? *BMJ* 2002; 325: 667-668.

Why patients trust doctors

Despite the media's fixation with medical errors and damaged patients, most doctors are good doctors in the eyes of most patients. Patients' ratings of doctors' interpersonal skills are strongly related to trust. To patients, trust means honesty, openness, responsiveness, having one's best interests at heart, and willingness to be vulnerable without fear of being harmed.

Coulter A. Patients' views of the good doctor: Doctors have to earn patients' trust. *BMJ* 2002; 325: 668-669.

Doctors and alternative medicines

This is an extremely important article for Indian physicians. The authors have defined a risk-benefit framework that can be applied to individual cases to determine appropriateness of using these therapies. The physician can formulate a clinically sound and ethically appropriate plan even in the absence of scientific evidence for these therapies by keeping certain well defined issues in mind.

Adams KE et al. Ethical considerations of complementary and alternative medical therapies in conventional medical settings. *Ann Int Med* 2002; 137: 660-664.

Why some people want to die

Oregon's 1997 Death with Dignity Act legalises physician-assisted suicide. Since then many hospice nurses and social workers have provided care for a patient who requested assistance with suicide. The majority of these requests had been discussed at a hospice interdisciplinary conference on patient care. Desire for control was a very important reason for these requests. Less important were depression, lack of social support and fear of being a financial drain on family members.

Ganzini L et al. Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *N Engl J Med* 2002; 347 (8): 582-588.

Is all technology good?

The author feels that as a society we are more fascinated by technology and losing touch with human issues. He illustrates his point of view by giving examples in his field where the latest technological advance is pushed indiscriminately.

Sarmiento A. Are we losing objectivity? *Journal of Bone and Joint Surgery* 2002; 84: 1254-1258.

Food or medicines?

This editorial comments on the promotion of dietary supplements of unproven value, as medication. Promotional techniques range from direct-to-consumer advertising, to getting doctors to prescribe them, and stocking them in pharmaceutical stores. It is unethical for doctors to prescribe untested products, particularly as "the poor of this country are made to continue paying through their nose for 'nutritional/dietary supplements' at the cost of two square meals a day," notes the writer.

Prescribing dietary/nutritional supplements: where is the evidence? Editorial. *Bulletin on Drug and Health Information* 2002; 9 (3): 65-67.

Social responsibilities in genetic research

The Australian National Health and Medical Research Council's guidelines on gene therapy have approved somatic gene therapy but recommended a temporary ban on germ cell gene therapy which makes inheritable changes with unknown long-term consequences. The writers examine the question: does our duty not to create new risks for future generations over-ride our duty to provide treatment to the present generation? They conclude that "the community

should take account of the interests of its successors but this should not immobilise us in the decisions we make for the present."

Loane S and Coady CAJ. Genetic manipulation and our duty to posterity. *Monash Bioethics Review* 2002; 21 (2): 12-22.

Can the poor give informed consent?

The writer describes her experiences as a member of an ethics review board and a professor at a public teaching hospital in Manila. Poverty and the marginalisation of the poor, a highly commercial medical system, the authority given to physicians, and impersonal, alienating hospital settings all combine to create an environment undermining people's ability to exercise free and informed consent. "In the Philippine research context, if a doctor requests a hospitalized patient to participate in a research project, then the patient is unlikely to refuse."

Alvarez-Castillo F. Limiting factors impacting on voluntary first person informed consent in the Philippines. *Developing World Bioethics* 2002; 2 (1): 21-27.

More on informed consent

Few practical guidelines exist on how to ensure that research participants in less-developed countries understand the consent form before enrolment. In a study of HIV-1 transmission in Haiti, participants were required to pass an oral examination on the contents of the consent form with a passing score of 12/15 (80%) before enrolment. Counsellors (80%) rather than physicians (20%) achieved better outcomes.

Fitzgerald DW et al. Comprehension during informed consent in a less-developed country. *Lancet* 2002; 360: 1301-02.

Making compassionate residents

House staff speak of residency training as a "test of survival" after which their "real" careers begin. However, these years will profoundly influence them as future physicians. Narratives are used in this academic programme to encourage self-reflection in order to make them better physicians, more compassionate caregivers and more fully developed human beings.

Brady D W et al. "What's important to you?": The use of narratives to promote self-reflection and to understand the experiences of medical residents. *Ann Int Med* 2002; 137(3): 220-223.

Do kidney sales benefit vendors?

The authors describe the economic and health effects of selling a kidney. The survey of 305 individuals who had sold a kidney in Chennai about six years prior to the survey revealed that the average amount received was $1070. The main reason for selling was to pay off debts. But 75% were still in debt at the time of the survey and over 86% reported a deterioration in their health status, with a 30% decline in family income after the nephrectomy. 79% said that they would not advise others to sell a kidney.

A commentary on this article summarises the various issues involved in the debate on cadaveric and living donor organ donation. Selling an organ has been advocated by some as a way out of poverty. The study provides clear proof that this is not true. The organ recipient is the only one who stands to gain.

Goyal M et al. Economic and health consequences of selling a kidney in India. *JAMA* 2002; 288: 1589-1593. Rothman DJ. Ethical and social consequences of selling a kidney. Commentary. *JAMA* 2002; 288: 1640-1641.

An ethical market in live organs?

An article suggesting that the selling and buying of human organs can be made ethical – with the trade channelised through a single buyer such as the government health service — triggered off a series of electronic responses. Marino and others point out that this system will appeal only to a restricted group of people, the cash-strapped. Wight notes that a market in live kidneys may lead to a collapse in organ donation, thus heart and liver transplantation could be seriously damaged. Wigmore et al question the notion that a single buyer would avoid donor exploitation. No guarantee exists that NHS would not exploit people. The potential for harm to the donor remains. Also, fair distribution among recipients needs to be addressed.

Harris J, Erin C. An ethically defensible market in organs. *BMJ* 2002; 325: 114-115. Letters in response: Marino, I et al. Market of organs is unethical under any circumstances. *BMJ* 2002; 325: 835 Aug 23. Wight, JP. Proposal is problematic. *BMJ* 2002; Aug 6. Wigmore, SJ et al. Defending the indefensible? *BMJ* 2002; July 26.

Informing legal judgements on medicine

Judges are expected to examine the basis of all expert testimony before it is introduced at trial to ensure that it meets the same standards of intellectual rigour that professionals use outside the courtroom. However, courts have been inconsistent in measuring this testimony against the standards of medical practice. Physicians should respond by correcting courts' misinterpretations of medical practice and assisting in the development of legal standards that encourage thoughtful and informed consideration of medical testimony by judges and juries.

Kassirer JP and Cecil JS. Inconsistency in evidentiary standards for medical testimony: disorder in the courts. *JAMA* 2002; 288 (11): 1382-1387.

Internet medicine and the law

The legal community needs to devise ways to address the expansion of medicine over the Internet. For a country like India, telemedicine and cybermedicine offer many advantages. However, concerns about quality remain. The book discusses malpractice, confidentiality, and informed consent as well as licensure, credentialing and liability; access including standards for use, confidentiality, privacy; and economic issues, reimbursement for services, funding and cost effectiveness.

Sivaswamy R and Kumar J. Doctors on the internet - legal and practical implications. *Eubios Journal of Asian and International Bioethics* 12 (2002), 185-8.