FROM OTHER JOURNALS

We scan the Annals of Internal Medicine *(www.annals.org),* New England Journal of Medicine *(www.nejm.org),* The *Lancet (www.thelancet.com),* British Medical Journal *(www.bmj.com),* Journal of Medical Ethics *(http://jme.bmjjournals.com),* Canadian Medical Association Journal *(www.cma.ca/cmaj.com), and Eubios Journal of Asian and International Bioethics (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 November 2007 - January 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.*

Judging quality of care

Patients judge a doctor's quality based on how they were treated by him or her, and not on how competent the doctor is in his or her work. Patients prefer a doctor who will listen patiently, provide detailed explanations, and respect their views when planning treatment. Using patient questionnaires to judge the quality of a doctor is likely to yield erroneous results unless the questionnaire is standardised and validated to assure accurate information.

Elwyn G et al. Respecting the subjective: quality measurement from the patient's perspective. *BMJ* 2007; 335:1021-22.

Asking about domestic violence

Domestic violence, while pervasive in the US, was not recognised as a health issue in the past. The situation has improved over the last 30 years but physicians still avoid asking about domestic violence and when they do the interview is often insensitive and demeaning to the victim. A study reveals that many physicians ask perfunctory questions or do not follow up on cues. The author emphasises the need for physicians to do better.

Alpert EJ. Addressing domestic violence: the (long) road ahead. *Ann Int Med* 2007; 147: 666-67.

What is bioethics really about?

The author, a bioethicist, says that bioethics has been hijacked by philosophers and has little practical wisdom. Autonomy of the individual and the right to self-determination are emphasised. However, every individual lives in a set of complex relationships that influence the choices he or she makes, and self-determination is not possible for most people who do not have the knowledge necessary to make the right choices. The author argues that bioethics should take into account the reality of the situation and always argue in the best interests of the patient.

Koch T. Bioethics? a grand idea. *CMAJ* 2008; 178:116.

Separating humanitarian from religious work

Faith-based NGOs may combine health care with proselytising work. This creates ethical concerns as NGOs may provide care to one community over another simply because it has greater potential for proselytising. Similarly, NGOs may rationalise proselytising as providing spiritual well-being to the patients. Yet this may actually increase mental turmoil for recipients and invade their autonomy if they have not specifically consented to receive such messages. The author feels that such NGOs should have strict guidelines that separate humanitarian work from religious work.

Jayasinghe S. Faith-based NGOs and healthcare in poor countries: a preliminary exploration of ethical issues. *J Med Ethics* 2007; 33: 623-26.

Provider-initiated testing for HIV

Provider-initiated HIV testing has aroused a lot of concern about the patients' right to confidentiality, but the authors argue that this focus on the patient ignores the rights of the patients' sexual partners.

Dixon-Mueller R et al. HIV testing: the mutual rights and responsibilities of partners. *Lancet* 2007; 370:1808-9.

Who pays for prescription practices?

A report on the Canadian health system has declared that physicians drive up health care costs by prescribing expensive brand name medicines even though cheaper generic drugs are available. Doctors often prescribe the newest drug because it is heavily promoted, but some times they have a good reason, such as ease of dosing. Pharmacists see patients more often for over-the-counter drugs, etc., and are in a better position to direct them towards cheaper versions. But pharmacists too suggest brand names as they get better commissions on them.

Howell E. Prescribing patterns drive up health care costs. CMAJ 2007; 177: 1487.

Who is responsible for the public's health?

The Nuffield Council on Bioethics has published Public health: ethical issues, a report that recommends that the UK government should introduce tougher public health measures. The authors, a group of physicians, philosophers and economists, prepared the report after wide-ranging consultations with many organisations and the general public. The main question posed was: who is responsible to make sure that people lead healthy lives? While it is primarily an individual responsibility, the report has provided ethical guidelines to determine when the state should act to promote health for an individual as well as for society. It also holds industry

responsible in promoting healthy practices.

The ethics of public health [Editorial]. *Lancet* 2007; 370:1801.

The case for and against decriminalisation

Califano, head of a drug addiction prevention centre in the USA, says decriminalisation will make drugs socially acceptable, leading to an increase in drug use, specially among the youth. Restricting drugs to adults only, as advocated by the pro-legalisation lobby, will not work, as shown by the ineffectiveness of similar laws for tobacco and alcohol. The author feels the best option is to reform the current drug policies and devote more efforts towards prevention and treatment of addiction. Chand, a general practitioner, counters that prohibiting alcohol and tobacco has not worked. Legalising drug use, as in the Netherlands, has not increased the number of addicts, and it allows addicts to be registered and treated as patients rather than as criminals. Legal drug sale will eliminate the violence and crime associated with it, and the taxes from the sale of drugs can be used to finance education on the harms of addiction.

Califano Jr, JA. Should drugs be decriminalised? No. *BMJ* 2007; 335:967. Chand K. Should drugs be de-criminalized? Yes. *BMJ* 2007; 335:966.

What a patient must do

The author puts forth 10 duties that an autonomous individual must adhere to when he or she seeks medical care from a publicly-funded health care facility.

Evans HM. Do patients have duties? *J Med Ethics* 2007; 33: 689-94.

Assessing medical students

The author, citing examples, points out inappropriate attitudes in medical students that could lead to future unethical behaviour with patients. While recognising the difficulty of changing fixed attitudes, the author argues for mechanisms to assess the attitudes of medical students and helping them develop better ones.

Whiting D. Inappropriate attitudes, fitness to practise and the challenges facing medical educators. *J Med Ethics* 2007; 33; 667-70.

End- of-life directives

"Allow natural death" and "Do not resuscitate" orders give the same directives about end-of-life care. Yet the authors demonstrate through a study using a questionnaire that AND is more acceptable than DNR to those with limited or no health care-background.

Venneman SS et al. "Allow natural death" versus "do not resuscitate": three words that can change a life. *J Med Ethics* 2008; 34; 2-6.

Learning about death

The author, a philosopher, describes his experiences during his participation in bedside teaching rounds. He was an observer at a cardiac arrest and resuscitation, and discussed the pertinent ethical aspects of the situation with medical students, in contrast to the usual general theoretical discussion on ethics. He describes how this hands-on experience gave him a new perspective on medical staff who must deal with death and dying on a daily basis.

Sharp RR. Teaching rounds and the experience of death as a medical ethicist. *J Med Ethics* 2008; 34; 60-62.

The case for and against male circumcision

Patrick feels that unlike female circumcision, male circumcision has little risk and has been shown to have medical benefit, such as less human papilloma virus infection and reduced incidence of HIV infection. Even though parents choose it for religious or cultural reasons rather than for its medical benefit, absence of convincing psychological trauma or unacceptably high rate of complications precludes banning the practice.

Hinchley feels that the rights of the child are ignored to protect the rights of the parents for religious freedom. Though the risks are low, they are not absent, and the adult male should be the one to decide to be circumcised, whether for cultural/religious reasons or for its medical benefits.

Patrick K. Is infant male circumcision an abuse of the rights of the child? No. *BMJ* 2007; 335:1181.Hinchley G. Is infant male circumcision an abuse of the rights of the child? Yes. *BMJ* 2007; 335:1180

Medical professionalism

The author compares the medical profession of today to craft guilds of the middle ages. The guilds became powerful by providing high-quality products that were in short supply. The cost was kept high by regulating the number of members through long apprenticeships. Eventually the high cost led to the decline of the guilds as customers found ways to reduce costs such as employing apprentices before they were full members of the guild. The author warns that if physicians do not heed the discontent of the public with rising health care costs, the medical profession too will go the way of the guilds.

Sox HC. Medical professionalism and the parable of the craft guilds. *Ann Int Med* 2007; 147: 809-10.

Capacity to consent

Through the example of a clinical case, the author discusses the difficulties of assessing the competence of a patient to give consent to a treatment or procedure. He outlines the various instruments available to asses the patient's ability to understand what is being communicated, and suggests options in case a patient is found incompetent.

Appelbaum PS. Assessment of patients' competence to consent to treatment. *N Engl J Med* 2007; 357:1834-40.

INDIAN JOURNAL OF MEDICAL ETHICS

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national bioethics conference

INVITING PROPOSALS
for hosting the *Indian Journal of Medical Ethics* third National Bioethics Conference, 2009

Two National Bioethics Conferences were organised in 2005 and 2007, in Mumbai and Bangalore respectively. Reports of these conferences are on the *IJME* website www.ijme.in .

Given the success of these conferences, it was decided that the third conference should be held in 2009, preferably between October and December. It is expected that the National Secretariat and the Local Secretariat will organise the conference in co-ordination. Based on the experience of the first two conferences, it is our experience that certain facilities are necessary to organise a successful conference.

The local organisers would be required to make the following arrangements

Infrastructure

* A venue for the conference, which is able to provide accommodation for at least 200 outstation delegates. It should have at least five large halls able to seat 50 persons each and one plenary hall able to accommodate at least 350 people;
* Office space to run a local secretariat for a period of six months prior to the conference.

Personnel

* At least one full-time staff member for the period of six months for the organisation of the conference, with the provision for an additional person if required;
* Two key persons would be required to participate in conceptualising the theme and sub-themes of the conference, fund raising and making physical arrangements for the conference from April 2006 onwards..

Activities

The local organisers are expected to carry out the following activities:

In co-ordination with the National Secretariat:

* Bring together and sustain a strong and cohesive organising committee through regular consultation and discussion;
* Raise funding from varied sources including government, non-government and multilateral agencies, while sustaining the independence of the conference;
* Prepare the concept paper, finalise the sub-themes through discussion;
* Mobilise abstracts on different aspect of bioethics, which are relevant to the theme of the conference, and conduct the review process and selection;
* Finalise the programme with workshops and other activities around the conference.

Independently:

* Mobilise local and national participants from different backgrounds and institutions beyond their own institution or network by approaching various other institutions, networks and agencies;
* Establish an effective communication channel to ensure a speedy response to inquiries from participants, authors, reviewers and organising committee members;
* Maintain accounts systematically and submit periodic reports to the collaborating organisations and funding bodies;
* Manage all the logistical arrangements prior to and during the conference.

The list is a guideline for potential applicants. Interested individuals or institutions should indicate their experience and capacity to meet the requirements listed above, submitting a proposal of 2-4 pages which includes the following:

* The names and details of the two key individuals who will be involved in the conference organisation;
* Details about the venue;
* Details about the infrastructure and personnel available.

The last date for receiving applications is June 30, 2008

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