An obsolete oath?

■ Does Hippocrates have nothing to say to the modern health professional? This writer argues that developments in medical technology, the growing importance of public health, the growth of private insurance, and a range of social changes all combine to challenge the principles contained in the Hippocratic oath. Powerful new interventions often do some harm; the absolute regard for life has been challenged by the dilemmas posed by high-tech techniques, and private insurance and public health demands have together eroded the notion of privacy. He suggests that doctors and society must get to grips with the ethical consequences of the medical revolution.

Imre Loefler. Why the Hippocratic ideals are dead. *BMJ* 2002;324:1463

Publication ethics

■ The writers looked at whether medical journals have improved their standards requiring researchers to describe the protection given to participants in clinical trials, in terms of mentioning whether informed consent was taken from participants, and whether ethics committee approval was sought and obtained. They compared 60 articles in each of five major general medical journals, for 1995-1999. While these journals improved their reporting of these two ethical requirements, 9% of studies still report neither informed consent nor ethics committee approval.

Veronica Yank, Drummond Rennie. Reporting of informed consent and ethics committee approval in clinical trials *JAMA*. 2002;287:2835-2838.

All about the kidney trade...

■ The fortnightly *Frontline* has carried a number of investigations on the kidney trade. The site (www.flonet.com) now has a collection of articles on the subject, which make up an excellent reference source (www.flonnet.com/ktrade.htm), with reports on networks in various parts of the country, a feature on a 'one-kidney community' of donors, articles on the law and on cadaver programmes. In an essay on the case for a "regulated kidney trade", the writer gives a brief outline of perspectives of the World Medical Association and other international and national bodies, and non-governmental organisations. She presents the arguments in support of organ sale, and the response to these arguments, drawing from academic debates, decisions of the World Medical Association and other organisations, and the experiences of medical professionals. She concludes: "New-fangled arguments for a paid-donor system cannot override its proven negative social and ethical consequences and implications."

Vidya Ram. Ethical and moral considerations. *Frontline* 2002 March 30-April 12; 10 (7).

Trying to bridge the 'donation gap'

■ The kidney trade in India sabotages efforts at establishing a cadaveric organ transplant programme. USA has a cadaveric programme, but although three out of four people asked say they would wish to donate, when actually asked for consent for donation of a relative's organs, only half of those asked agree. USA still faces a crisis in donations, resulting in about 4,300 deaths in 2001. This leads to desperate patients buying organs from outside the country. Efforts to promote donation include improving public awareness, scrutinising existing approaches to getting consent from relatives, incentives and even payments. This report discusses efforts to improve the manner in which patients' relatives are approached for consent. A study of 420 families found that those who spent more time discussing donation with organ procurement organisation staff were more likely to consent, as were families who were asked to make a decision only after such discussions. The more radical approach of presumed consent, in which all deceased patients become potential donors, has not been taken up at the policy level.

Brian Vastag. Need for donor organs spurs thought and action *JAMA* 2002; 287 (19).

Ethical incentives to organ donation

■ This essay considers the possibility of giving incentives to promote organ donation. This suggestion is made in the context of a growing reliance on living donation – and the attendant risk of financially motivated donation. The authors argue that both presumed consent and mandated choice (requiring all citizens to state whether or not they will donate) have limitations in a country such as the US. The existing shortage also leads people to the black market for organs. Though the National Organ Transplant Act prohibits the selling/buying of organs, for-profit companies have already become processors of other transplantable tissues. Many bills are in the pipeline to promote donation; some effectively legalise payment for organ donation.

They suggest other ethical incentives to increase organ donation – from both, living donors and from cadavers — which would not amount to payment. These could include some kind of public honour, a small reimbursement for funeral expenses, medical leave for organ donation, and life and disability insurance for donors. Tax credits or refunds — both suggestions made in proposed legislation — are effectively payments, which the authors oppose.

Delmonico, F L et al. Ethical incentives — not payment — for organ donation. *NEJM* 2002 346 (25): 2002-2005

Unequal medical care

■ "In almost every nation in the world, increased burdens of morbidity and mortality afflict racial and ethnic minorities and new immigrant populations." While poverty and poor access play a role in this situation, the author also points to research findings that minorities who do use the system are also treated differently– from the quality of work-up, to getting specific procedures, or medications – even when factors such as age, sex, economic status and insurance coverage were taken into account. There is evidence in some studies that the patients who were denied appropriate or necessary care included some who were at greatest risk,

and who suffered accelerated mortality consequently. This goes against the commitment to equal care for all.

Of the many possible reasons for this disparity, the writer argues that physician bias affecting clinical decision-making, and cultural incompetence, are the most directly remediable. Both the US and the UK have taken steps to address racism in health care. Medical students are also being trained to work in multi-cultural settings. Most examples of uneven treatment are not to do with conscious bias, but the indirect results of time pressures and the complex nature of the job. Also, health care workers will reflect the biases in mainstream society and the culture of medicine. Reducing racially or culturally based inequity in medical care is a moral imperative.

H Jack Geiger. Racial stereotyping and medicine: the need for cultural competence Commentary. *CMAJ* 2001; 164 (12).

Racism in medicine

■ This book review of *Racism in medicine*, by a UK physician of Asian descent, presents another facet to the issue of racism in medicine, relevant to India. The author states that the book provides ample evidence of racism within the health services – directed at patients by health professionals, at students by teachers, at health professionals by their colleagues as well as by patients. The profession cannot afford to be complacent about the problem; nor can it wait for more research. What is needed now is a sense of responsibility to change the situation, and action to implement existing legislation.

Raj Bhopal. Racism in medicine: the spectre must be exorcised www.studentbmj.com/back_issues/0801/editorials/262.html

Doctors in conflict

■ A UK doctor on his way to volunteer in the emergency department of a Palestinian hospital for the Palestine Red Crescent Society was denied entry "for security reasons" and deported from Tel Aviv airport. He wrote on the wall of the holding cell: " I was denied entry because I came to give humanitarian assistance... My duty as a doctor is to give help to those in need, irrespective of race, nationality, religion, or political beliefs. That includes Palestinians."

As a result of the Israeli government's policy, 2,000 humanitarian aid workers and human rights activists were barred from entering Israel in a month; 50 were deported.

Ben Alofs. Occupied Territories: entry denied. *BMJ* 2002;324:1225

Health care workers and war

■ What can health care workers do about the threat of war? This is certainly an urgent task before the medical profession in this region. The writers believe that doctors can support efforts to prevent the use of certain weapons (such as nuclear or biological weapons), draw public attention to the health effects of war; support efforts at peace-making. Also, they can support the rehabilitation of all those affected by war, by building an equitable, accessible healthcare system. Doctors should use their skill in maintaining the well being of humans, as well as our legitimacy as healthcare workers, to seek medical, social, and political solutions that help eradicate or limit this disease that afflicts humanity."

Salim Yusuf, et al. Can medicine prevent war? Imaginative thinking shows that it might *BMJ* 1998;317:1669-1670

Case studies on health and human rights

■ The skills of physicians, medical and forensic scientists, and other health workers are uniquely valuable in human rights investigations and documentation, producing evidence of abuse more credible and less vulnerable to challenge than traditional methods of case reporting.

This article presents case studies from the field missions of Physicians for Human Rights on investigation and documentation of violations of medical neutrality, refugee health crises, use of indiscriminate weapons, torture, deliberate injury, rape, and mass executions. Participation of health workers in the defense of human rights now includes investigation and documentation of health effects in threatened populations as well as individual victims.

Geiger HJ, Cook-Deegan RM. The role of physicians in conflicts and humanitarian crises. Case studies from the field missions of Physicians for Human Rights, 1988 to 1993. *JAMA* 1993 270(5): 616-20.

Doctors at the time of Apartheid

■ This report documents the role of white health professionals in South Africa during a time of state-supported racism ignored. It finds that they supported apartheid in violation of international medical standards, by refusing treatment; falsifying medical records to cover up evidence of torture; turning over wounded political demonstrators, without treatment, to the security forces, and violating patient confidentiality to cooperate with security forces. "The conduct of the leaders of health professional organizations was in many respects the most egregious of all," the report concludes.

Human rights and health: the legacy of Apartheid. *American Association for the Advancement of Science and Physicians for Human Rights, in conjunction with The American Nurses Association and the Committee for Health in Southern Africa, Washington, DC, December 1998.*

Changing responsibilities

■ Health professionals can "apply their skills and knowledge in many increasingly complex emergency settings," write the editorialists. They have documented the health consequences of human rights violations, to establish criminal responsibility and to prevent them from being repeated, usually through case testimonies.This editorial comments on a study to establish patterns of human rights violations among Kosovar refugees by Serbian forces.

Iacopino V, Waldman RJ. Editorial. From Solferion to Kosovo: the evolving role of physicians. *JAMA* 1999; 282 (5).