

Refusal to care for people with HIV

■ This study based on a mailed survey to random group of Canadian dentists had a response rate of 66 per cent. Thirty-two per cent of respondents had knowingly treated HIV-infected patients in the last year. One in six reported that they would refuse to treat people with HIV. Refusal to treat was associated with a 'lack of ethical responsibility', fear of cross-infection or lack of knowledge of HIV. The writers note: "These results have implications for undergraduate, postgraduate, and continuing education." Wonder where we stand on the subject.

McCarthy GM et al. Factors associated with refusal to treat HIV-infected patients: the results of a national survey of dentists in Canada. *Am J Public Health* 1999 89: 541-5.

The right not to tell?

■ The writers describe a prolonged negotiation, over five years, between the parents of an adolescent boy with HIV / HCV co-infection, and the medical professionals treating him. The doctors wanted to inform the boy of his HIV and HCV status. The parents refused to permit this until they were forced to, legally, when the boy turned 18. The discussion illustrates the difficulties in making ethical decisions. Both doctor and parent have good intentions for the child. Some questions for the medical professional are: how does one respect the rights of parents as well as the emerging autonomy of the child? Could a well-intentioned decision do more harm than good?

Roshni Kulkarni, et al. Nondisclosure of Human Immunodeficiency Virus and Hepatitis C Virus coinfection in a patient with hemophilia: medical and ethical considerations. *Journal of Pediatric Hematology/Oncology* 2001; 23: 153-8.

When parents think otherwise

■ What are the choices before a paediatrician when an HIV-positive mother rejects medical recommendations on breast-feeding and anti-retroviral prophylaxis? And what guides an appropriate response? This article analyses the legal and ethical issues that arise as a consequence.

This problem has not yet arrived in India where only the rich have access to such drugs, and insisting that women not breast-feed can be simply idiotic. Still, doctors already certainly face ethical dilemmas in choosing between two obligations — to protect the infant and to respect parental decision making.

Wolf LE et al. When parents reject interventions to reduce postnatal human immunodeficiency virus transmission. *Arch Pediatr Adolesc Med* 2001; 155: 927-33.

Training, morale and material

■ This study analysed retrospective data from 732 and prospective data from 960 nurses on needlestick exposures and near misses, and collected information on staffing levels and survey data on the working climate and risk factors for needlestick injuries from 40 units in 20 hospitals. Nurses

from poorly-staffed and badly organised units were more likely to report risk factors, as well as injuries and near misses. The remedy: improve staffing, administrative support, and morale.

Clarke Sean P, et al. Effects of hospital staffing and organizational climate on needlestick injuries to nurses. *Am J Public Health* 2002; 92: 1115-1119.

Unethical practices by tobacco industry

■ This report based on an investigation of tobacco company documents illustrates unethical practices resulting from financial ties between the tobacco and pharmaceutical industry with three case studies linking tobacco companies with firms marketing tobacco cessation material. In the first, tobacco companies pressured pharmaceutical companies to tone down educational materials accompanying the product. In the second, they restricted the product's marketing, and in the third, subsidiary tobacco and pharmaceutical companies of a parent company actually collaborated in the production of a nicotine-release gum.

Bhavna Shamasunder and Lisa Bero. Financial ties and conflicts of interest between pharmaceutical and tobacco companies. *JAMA* 2002; 288:738-744.

Ethicist for a medical journal

■ This is a report on the *Canadian Medical Association Journal's* appointment of surgeon John Dossetor as its ethicist and ombudsman, the first appointments of their type for a Canadian scientific publication". Dossetor who coordinated Canada's first kidney transplant, later supervised Canada's cadaver transplant programme at a time when there were no ethics committees, and one heard frightening stories about what doctors did in the patient's best interest. As a researcher, he grew increasingly concerned about ethical dilemmas arising from medical advances, including in his own practice when a patient brought someone willing to sell a kidney. "It made me think that bioethics was becoming an increasingly important field." But he cautions readers against expecting clear-cut solutions to issues they raise. "Ethics is not about answers. Ethics is about asking more questions."

Sibbald Barbara. CMAJ appoints first ethicist/ombudsman. *Canadian Medical Association Journal* 2002 May 14; 166 (10): <http://www.cmaj.ca/cgi/content/full/166/10/1327-a>

Ethics and public health

■ The July 2002 issue of the *American Journal of Public Health* starts Health Policy and Ethics Forum, a regular column for "discussion on ethics in public health research and practice". The lead editorial notes that public health ethics is all about "the need to exercise power to ensure the health of populations and at the same time to avoid potential abuses". One of the papers concerns the role played by institutional review boards in the monitoring of research. Among the essays on the topic in this issue are three papers on non-therapeutic research on non-consenting subjects.

Do parents have the right to consent on behalf of their children? Two other articles on international collaborative research look at the promises and pitfalls of the genomic revolution, and on the need to recognise the rights and 'agency' of vulnerable in the ethical review process. The issue also contains a code: Principles of Ethical Public Health Practice, which has been formally accepted by the American Public Health Association, and which is available on www.apha.org/codeofethics.

Health policy and ethics forum. *Am J Public Health* 2002; 92: 1056-59, 1067-84.

http://www.ajph.org/content/vol92/issue7/index.shtml#HEALTH_POLICY_AND_ETHICS_FORUM

Informed choice in screening programmes

■ In the UK, there is a shift towards 'informed choice' as an ethical imperative in screening programmes. The authors look at whether such how this change will affect screening for risk of coronary heart disease in primary care.

Screening programmes are public health efforts calling large populations to participate for benefit from the information that might be obtained in such tests. In India, the health check-ups advertised by corporate hospitals are essentially screening programmes, though their value – as they are run today — may be questioned. One important component of screening programmes is the positive message they send, that early detection will be of benefit to the individual undergoing the tests. There is no mention of the possibility of psychological and physical harm that can be caused by a false positive test for cancer, for example, or the consequences of prenatal screening results.

Marteau Theresa M, Kinmonth Ann Louise. Screening for cardiovascular risk: public health imperative or matter for individual informed choice? *BMJ* 2002;325:78-80.

An 'ethical market' in live organs'

■ This editorial follows up on the American Medical Association's decision to encourage studies to see if financial incentives would increase cadaver organ donations. The authors describe "an ethical market in live organs". Channelising the organ trade through a single buyer, such as the government health service, would prevent exploitation of the poor, ensure equitable distribution of organs, and address safety concerns, they argue.

"Nothing we have said rules out altruistic donation as a mode of organ procurement alongside a commercial scheme; we would not wish to discourage donation."

Harris John, Erin Charles. An ethically defensible market in organs. A single buyer like the NHS is an answer *BMJ* 2002; 325: 114-115.

Unethical drug promotion

■ This editorial comments on the ethical problems inherent in pharmaceutical advertising, and discusses various efforts to address the problem. Aggressive medical reps, medical sponsorship, direct to consumer advertising...

the list of dirty tricks is endless.

The WHO's 'Ethical criteria for medicinal drug promotion' are flouted with impunity; the International Federation of Pharmaceutical Manufacturers' Associations' code of pharmaceutical marketing practices is ignored in developing countries, and efforts to monitor advertising material in journals rarely work. In India, legislation on drug advertising has not been enforceable.

However, the writer notes, students at a few medical colleges are being prepared for such tricks. They are being taught to 'take control' of the interview with the medical representative to be informed according to their needs, not those of the industry.

Such efforts may be tiny but incremental, and perhaps doctors will start demanding ethical behaviour of drug companies. "Unless this demand comes from the medical establishment who refuse to take lavish gifts, eat lunches and dinners sponsored by drug companies, and attend CME programmes paid for by the companies we can never expect drug companies to self regulate."

Thawani Vijay. Drug promotion: can self-regulation work? *Indian Journal Of Pharmacology* 2002; 34: 227-228.

Breaking bad news

■ How much should a physician tell his patient the whole truth about a potentially terminal illness like cancer? Should s/he speak to the patient or relatives? In a country like India, there are many opinions on this subject. Japanese courts have held that cancer disclosure is at the physician's discretion. This perspective is changing on the basis of legal decisions on medical malpractice cases. The author reviews these legal decisions, and notes the need for mental and physical support to the patient when making such disclosures.

Takanami S. Cancer disclosure from recent medical malpractice cases in Japan. *Eubios Journal of Asian and International Bioethics* 2002; 12: 19-21.

The culture of poverty?

■ The writer discusses some ethical aspects of research in poor communities, which comes with extra obligations, since people's autonomy will be compromised by their circumstances. At the same time, "Poverty has its own cultural values, its own perception of beneficence, non-maleficence and justice, which may differ from those of the medical doctors and researchers."

Azevedo ES. Decisions in circumstances of poverty. *Eubios Journal of Asian and International Bioethics* 2002; 12: 105-7.