

## FROM OTHER JOURNALS

We scan the *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), *British Medical Journal* (www.bmj.com), *Canadian Medical Association Journal* (www.cma.ca/cmaj), *Journal of Medical Ethics* (www.jmedethics.com) and *Eubios Journal of Asian and International Bioethics* (www.biol/tsukuba.ac) for articles of interest to the medical ethics community. For this issue of the *IJME* we reviewed the November 2003–January 2004 issues of these journals. Articles of interest from 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 that you feel should be included, please forward it to mmamdani@comcast.net

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### **Need for local research capacity**

*The following article persuasively points out why research relevant for India will have to come from within.*

Academic professionals in developing countries work in isolation from primary care settings. Most have to contend with an enormous load of teaching and clinical care. There is little continuing medical education and even rarer access to recent biomedical information, with the pharmaceutical industry filling the gap. Salaries of academic professionals are insufficient to support a white-collar lifestyle. Most of them resort to private practice. This further encroaches on scarce time. Therefore, few are involved in developing and testing public health interventions. Strengthening centres of learning and creating local capacity for conducting and monitoring research are critical for the promotion of academic medicine in developing countries.

Bhutta Z. Practising just medicine in an unjust world; initiatives to improve academic medicine in developing countries must come from within. *BMJ* 2003;327:1000-1

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### **Consent for tissue samples**

*Most Indians are unaware of the research and teaching value of tissue samples taken during surgery. Therefore, a separate consent is not taken from Indian patients for such use of their tissues. Yet it is important for the Indian medical profession to be aware of the attitudes of the public. This issue will surface in India sooner or later.*

The authors interviewed 100 healthy volunteers to assess what types of tissue individuals would be prepared to donate for research, what types of research would be acceptable, whether parents would consent to the donation of a child's tissues, and whether their tissues could be used for teaching. They discovered that one in five would not agree to donate any tissue, perhaps reflecting recent negative publicity surrounding post mortem organ retention and reports of medical malpractice/criminal behaviour. Donation of some tissues such as the eye and brain were unacceptable, while ovarian/testicular tissue was not, perhaps because patients were familiar with egg and sperm donation for fertility treatments. The majority agreed to donate in case of use

for cancer research but fewer agreed for research in genetic disorders or genetic cloning. A majority favoured some ongoing control over tissues removed at surgery. Although a detailed ethical review in 1995 concluded that a patient's consent to the removal of tissue implied consent to its subsequent use for any ethically acceptable purpose, this view is not universal. Educating the public in the principles and practice of medical research may change this attitude. Goodson ML *et al.* A study of public opinion on the use of tissue samples from living subjects for clinical research. *J Clin Pathol* 2004;57:135-8

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### **Need for relevant research**

*Research is not an elite, academic endeavour that drains scarce resources from daily clinical practice. Instead, it is essential for creating practical and relevant health systems. That is the message of the following article describing the WHO's plans for the next decade.*

In November 2004, at an international summit organised by the WHO on health research in Mexico, the overriding question will be what research is needed to reach the Millennium Development Goals (MDGs) by 2015. This research must return to the values of Alma Ata—WHO's 1978 commitment to primary health care. All countries should have a health research system that drives health sector reform. Research should be applied to improve health equity and must be conducted according to universal ethical standards. The results of research should be accessible to all. Civil society has a vital—and so far neglected—part to play in setting research priorities.

Mexico, 2004: Research for global health and security [editorial]. *Lancet* 2003;362:2033.

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### **Research on children**

*Research on children is essential to prevent harm as the following article states persuasively.*

Children are a vulnerable group that needs protection from the potential harm of participating in a drug study. Therefore, few drugs are tested in children; paediatric prescribing largely involves educated guesses about doses, safety and effectiveness. Lack of information either deprives children of the benefits of drug therapy or exposes them to unknown side-effects. The most common

hindrances cited are ethical, technical and logistic. To rectify this, the US has recently taken the lead in offering incentives for including children in trials.

Matsui D *et al.* The trials and tribulations of doing drug research in children. *CMAJ* 2003;169:1033

### Concordance of patient and physician

*We cannot always match patient and physician in a country as diverse as India. Yet, the following article may help physicians who want to increase the level of satisfaction among their patients. This is especially important when dealing with disadvantaged groups.*

All patients are sensitive to the affective climate of the medical encounter; however, because of historical and personal experiences with discrimination, African–American patients may be especially sensitive to interpersonal cues from their physician that convey a message of caring, trustworthiness and partnership. To study this, the authors audiotaped 252 primary care visits monitoring whether communication was more patient-centred than physician-centred. When both physician and patient were African–American or both were white, the visit was about two minutes longer and the patient's affect was more positive but, surprisingly, was not more patient-centred. This positive affect may thus reflect factors such as mutual liking and respect, a sense of social or racial group affiliation and enhanced trustworthiness or positive expectations.

Cooper, LA *et al.* Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med* 2003;139:907–15

### Palliative care for AIDS

*AIDS has devastated Africa and some predict a similar fate for India. The bulk of resources have been allocated for prevention as anti-retrovirals are still beyond the reach of the average patient. The best that can be offered to an individual with AIDS is death with dignity. India can learn and adapt the programme described here.*

Uganda is the first and only African country that has made palliative care for people in the terminal stages of AIDS and cancer a part of its national health plan. Cheap, powdered morphine has been the keystone of Uganda's affordable, modern palliative care movement, Hospice Uganda. The Ugandan government agreed to make free morphine available when the Hospice was established, and modified statutes to allow nurse specialists to prescribe morphine. The hospice had to overcome fear and myths about morphine in the early years. Hospice training includes lectures on practical and psychological factors in pain management and symptom control, together with lectures on cultural beliefs and the use of local remedies.

Ramsay S. Leading the way in African home-based palliative care. *Lancet* 2003;362:1812–13.

### The medical maze

*All patients, irrespective of economic class, find hospital stay bewildering and frightening. The NHS in the UK has adopted some methods to make them less so. Can we in India adopt their methods?*

When a child develops a serious medical condition, parents are rapidly thrown into a turmoil of shock and anxiety. Medical care can be messy, is often painful, and the outcome may be uncertain. Parents may suddenly have to hand over the responsibility for care of their children to staff they hardly know. Witnessing the distress of one's sick child is one of the hardest situations for parents to be in. They look at doctors and nurses as helpers and companions in the fight against disease and death. Too often, however, we fail in these compassionate roles. Some specialties such as transplantation surgery and oncology have people who act as a link between the medical team and family, and often guide a family through the medical system and beyond throughout the patient's life. Many have a nursing background and have now become a patient's and a family's advocate, giving practical and emotional support in and out of hospital. The writer of this editorial describes the UK National Health Service's Patient Advocacy and Liaison Service in each Trust hospital, which employs on an average 2.5 full-time staff per hospital who provide support, education, and an open ear for any concerns.

Wanted: help through the jungle of hospital care [editorial]. *Lancet* 2003;362:1947

### Direct advertising

*We are aware of the hazards of advertising of pharmaceuticals but are not as familiar with the hazards of aggressive advertising of preventive medical services which include the latest in diagnostic tests. The following article from Australia may be of relevance to us in India as well.*

The growth in direct medical advertising of diagnostic tests, such as virtual colonoscopy and heart scans, has occurred without being widely debated in the community or within the profession. This is in stark contrast to the recent vigorous debate on direct advertising of pharmaceuticals to consumers. Some would say it is the consumer's right to choose and buy in a free market and that medical advertising is adequately controlled by legislation, such as the Trade Practices Act 1974, which prohibits misleading or deceptive advertising. But medicine should be regulated by medical associations based on medical principles and not by trade associations based on trade principles.

Van Der Weyden MB. Marketing medicine. *Med J Aust* 2003;180: 97

### Quality of care

*We tend to focus on the most sensational lapses of the health care system while ignoring major issues such as access and distribution. The latter cause far more preventable deaths.*

*That is the message of the following article, which has particular relevance for India as the health care industry begins to emulate its counterparts in the West.*

Safety is an essential goal for health care. However, patients deserve far more than not to be harmed by their physicians. Improving safety is vital, but it should not distract from the larger mission of helping people maintain their health and cope with illness, of which safety is only one component. The medical profession should focus on this larger purpose and not on fragments. Woolf SH. Patient safety is not enough: targeting quality improvements to optimize the health of the population. *Ann Int Med* 2004;140:33–6

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### **Doctored admissions**

*This article, written in a wonderful anecdotal style, describes corruption in medical entrance exams and the extent to which it is organised.*

In what appears to be sound business tactics, the players practically guarantee the student concerned marks good enough to ensure entrance into a medical college—this by releasing most of the questions a few hours before the actual examination. If something goes wrong and the questions leaked do not actually appear in the question paper, not only is the money refunded (no questions asked), but a 20% concession is offered at the next appearance. The problem, as the writer points out, is that terms such as medical ethics will be wasted on people who use unethical,

illegal and devious routes to get into medical colleges. Serving the poor will be the last thing on their minds as they try to recover their investment and make a profit as well.

Anand AC. Doctored admissions: are we sowing the right seed? *Natl Med J India* 2003;16:328–30.

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### **Abuse during childbirth**

*Women giving birth are particularly vulnerable to abuse by health care personnel, and perhaps more so in public hospitals. This qualitative investigation documents factors facilitating violation of women's reproductive rights during childbirth in Mexico. It is based on approximately 200 testimonies, and formal and 64 systematic direct observations in birth and labour rooms in two large public hospitals. The issues raised here are definitely applicable to India.*

Three patterns of behaviour during childbirth are identified, which result in violation of women's reproductive rights. Health care personnel use their positions of power and control to intimidate women. The report documents the use of coercion, threats and physical punishment to obtain consent for the insertion of contraceptive devices. Women unaccustomed to defending their rights accept the role they are forced into as hospital patients. And public health institutions discourage women from pursuing formal complaints.

Castro R, Erviti J. Violations of reproductive rights during hospital births in Mexico. *Health and Human Rights* 2003;7: 90–110.