

FROM OTHER JOURNALS

We scan the *Annals of Internal Medicine* (www.annals.org), the *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.com), *Journal of Medical Ethics* (www.jmedethics.com) and *Eubios Journal of Asian and International Bioethics* (www.biol.tsukuba.ac.jp/~macer/EJAIB.html) for articles of interest to the medical ethics community. For this issue of the *IJME* we reviewed the August-October 2004 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.

Publishing ethics

The concept of an ethics committee in a hospital is accepted universally. However, the idea that medical journals benefit from such committees is new and has been implemented at the British Medical Journal. Medical journals in India stand to gain from such experiences.

This report on the *BMJ* ethics committee describes the types of cases it has reviewed since it was established four years ago to help editors with difficult cases, to review policies that have ethical implications, and to expand the journal's coverage of ethics. The discussions covered three broad themes: patient confidentiality, responsibilities to those outside the publishing process, and research misconduct.

Wager E. Experiences of the *BMJ* ethics committee. *BMJ* 2004; 329: 510-512.

Editors' conflicts of interest

It is time editors of prestigious journals too, not just authors, declare their conflicts of interest.

Although many journals now publish authors' financial conflicts of interest, and reviewers are asked to declare if they have a conflict of interest with regard to individual manuscripts, little is known about editors' conflicts of interest and the mechanisms to manage them. Editorial conflicts can operate at many levels beyond financial interest: editors may entertain a dislike for certain authors; an author's work may compete with or contradict an editor's own work; or an editor, having decided not to publish a particular author's submission, may be tempted to pursue the same idea. The *BMJ* publicly declares the financial and non-financial conflicts of interest of its own editors and editorial board members. The authors – affiliated to the *BMJ* at the time – surveyed journal editors on their conflict of interest policies for editors and reported that few journals have a policy on the subject.

Haivas, I et al. Editors' declaration of their own conflicts of interest. *CMAJ* 2004; 171 (5): 475.

Changing sex ratios in the medical profession

For many years now, the number of women doctors has equaled, if not exceeded, the number of male doctors in India. The US is now catching up.

The authors predict changes in four domains as a result of women begin to constitute the majority of practicing physicians in the USA: the patient-physician relationship, the local delivery

of care, the societal delivery of care, and the medical profession itself. They emphasise that they are not saying that women make better physicians than men; they only wish to highlight some of the potential advantages and disadvantages of this change in the physician workforce.

Levinson, W and Nicole Lurie. When most doctors are women: what lies ahead? *Ann Int Med* 2004; 141(6): 471-474.

Social class and health

In India, it is important to recognise the effect of people's caste and socioeconomic background on their access to health care. The following article looks at similar issues from the US perspective.

The authors make the point that though the American public enjoys good health, there is a gap between the health status of the predominantly white affluent upper classes and the lower classes where blacks, Latinos and other ethnic minorities predominate. Differences in rates of premature death, illness, and disability are closely tied to socioeconomic status. Concentrating mainly on race as a way of eliminating these problems downplays the importance of socioeconomic status on health. There are many ways of measuring class, the most widely accepted being in terms of income, wealth, education, and employment. People in lower classes die younger and are less healthy than people in higher classes. Factors that contribute to premature mortality amongst the less affluent include life-styles (smoking, unbalanced diet, and a lack of exercise) contributing to a reduced life span; inadequate health insurance coverage; living in worse neighbourhoods, and greater exposure to environmental hazards. Beyond that, however, there is something about lower socioeconomic status itself that increases the risk of premature death. Although there is wide agreement that people of higher socioeconomic status live longer and healthier lives than people of lower socioeconomic status, there is less consensus on why this is so or which factors are most responsible. Education, employment, and income are considered important.

Recent research has linked poor health to the constant stress of a lower-class existence – a lack of control over one's life circumstances, increased social isolation, and the anxiety brought about by a subjective feeling of being of low social status (all of which can be compounded by racism). Physiologically, stress appears to trigger a neuroendocrinologic response that is beneficial in the short term but over the long run can weaken the body's resistance to illness. If the US is serious about improving the health of its people it will have to go beyond expanding

medical care, changing unhealthy behaviour and improving the environment, and give more attention to social policies that address the class – as well as the racial and ethnic – differences that underlie illness and premature death.

Isaacs, SL S A Shroeder. Class -- the ignored determinant of the nation's health. *N Engl J Med* 2004; 351(11): 1137-1142.

Finders' fees in clinical trials

As the outsourcing potential for India's clinical trial industry grows, so will the conflicts of clinicians when they get paid to recruit patients in such trials. This essay looks at how such conflicts have been discussed in Canada and what more needs to be done.

Physicians who participate in clinical trials gain academic benefits, prestige and, in industry-sponsored trials, additional income. Currently there are no standards in Canada for what a physician should be paid for such participation. Information on such payments is unavailable to institutional review boards; in multi-centre trials they are not even shared between institutions.

While financial conflict of interest is subjective and may never be completely avoided, it is important to avoid payments that could be seen as a threat to scientific integrity or good clinical judgment. There is a consensus that some physician payments should be banned, like finders' and completion fees. However, there has been little debate on the question of clinical trial budgets and what a reasonable physician remuneration is. The authors urge standardisation of categories of remunerable services, agreement on how physician payment levels should be set and transparency regarding the budgetary provisions in clinical trial agreements.

Ferris, LE and C David Naylor. Physician remuneration in industry-sponsored clinical trials: the case for standardised clinical trial budgets. *CMAJ* 2004; 171(8): 883

Ethical review in collaborative research

Is the ethical review of collaborative research getting too complex and counter-productive? How can it be simplified while ensuring the protection of research participants? This article examines such questions.

Institutional review boards (IRBs) in developed and developing countries tend to operate on the presumption that investigators are intent on exploiting disadvantaged and poorly educated subjects. This perception has given rise to an ethics review system for international research that is unnecessarily complex and legalistic. This exaggerated response is detrimental to the promotion of research in developing countries and does not result in better protection for research subjects. There is now a large, built-in administrative infrastructure involved in ethical review at several levels, including funding agencies, universities, nongovernmental organizations and governmental bodies. The authors are not arguing for an eased ethical standard, or to bypass IRB review in either developed or developing countries; they hold that an equally high standard of protection could be achieved with a less legalistic and repetitive system. A thorough, stringent review by one developed and one developing country institution is sufficient to adequately protect the rights of study

participants. They suggest three strategies to ensure the ethical protection of human subjects in developing countries while also encouraging research. First, no more than two institutions should be in charge of the ethics review of international studies: the institution of the principal investigator and the institution of the principal foreign collaborator. Second, whenever feasible, the developed country review panel should consist of people who have spent time working in the developing world. Third, the consent document should be the one approved by the local IRB.

Gilman, RH and Garcia Hector H. Ethics review procedures for research in developing countries: a basic presumption of guilt. *CMAJ* 2004; 171(3): 248

Promoting ethical discussion among students

The authors describe a two-week course offered as a special study module to second- and third-year undergraduate medical students in the UK. Students research the various aspects of ethical dilemmas that they have identified themselves during their medical school clinical rotations, and "teach" these issues to their colleagues in a presentation as well as prepare an extended essay. The objective is to promote critical thinking capacity in ethical and moral issues as a prelude to the development of practical skills in dealing with clinical problems.

Roff, S and Preece P. Helping medical students to find their moral compasses: ethics teaching for second and third year undergraduates. *J Med Ethics* 2004; 30 (5): 487-489.

More on medical education

Medical students and doctors in training need to hone their clinical skills on patients to make themselves better doctors, but patients may not benefit directly from such attention. This ethical dilemma has not been studied adequately. The authors compare medical education with medical research and suggest that the principles guiding medical research – namely, respect for individuals, beneficence and distributive justice – can be applied by educational institutions to develop more ethical ways of teaching students.

Jagsi, R et al. The ethics of medical education. *BMJ* 2004; 329 (7461): 332-334.

The complexities of informed consent

Obtaining informed consent is an essential part of ethical human research. However, it is one thing to require it, another to actually implement it, especially in developing countries. This paper reviews existing guidelines for obtaining informed consent and discusses some problems. The author argues that the detailed documentation required by most externally funded research projects in developing countries do not necessarily assure true comprehension and voluntary participation. It is crucial that all relevant details of the research, the potential participant's contribution, and risk and benefits are communicated clearly. Researchers must ensure that potential participants understand that participation does not provide a benefit, or non-participation a harm; they must ensure that participants are in a position to give truly voluntary consent, and they may have to document it in different ways. The author also looks at issues such as community consent and public consultation in

