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 *(http://www2.unescobkk.org/eubios/EJAIB.ht) for articles of interest to the medical ethics community. For this issue of the* IJME *we reviewed the August 2005 - October 2005 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.*

Drug companies' code of practice

The editorial writer comments on the revised code of practice of the Association of the British Pharmaceutical Industry's (ABPI). The code ensures that UK pharmaceutical companies act, as the ABPI requires, in a responsible, ethical, and professional way when promoting their prescription products. This code, which was revised after 10 years, aims to increase transparency particularly of adverse events. Unfortunately it does not cover non-prescription drugs.

Editorial. The UK drug industry: responsible, ethical and professional? *Lancet* 2005; 366:1828

Conflicts of interest

This editorial reflects on its current practice under which articles recommending drugs are not accepted for publication if one of its authors has a significant financial conflict of interest. Exception to this rule had been clinical practice guidelines where a statement of such a conflict was sufficient. However CMAJ found that these do exist and occur far more often than is suspected. They cite an example in detail. As a result CMAJ is reconsidering its publishing policy.

Editorial. Clinical practice guidelines and conflict of interest. *CMAJ* 2005; 173: 1297.

A call for a correction

Editors question the integrity of article because of inaccuracies and deletions of data from the article which came to light as a result of the litigation related to this drug. They have asked the authors to submit a correction to the journal.

Curfman, GD et al. Expression of concern: Bombardier et al., "Comparison of upper gastrointestinal toxicity of Rofecoxib and Naproxen in patients with rheumatoid arthritis," *N Engl J Med* 2000;343:1520-8. *N Eng J Med* 2005; 353: 2813-2814.

Researchers must involve the community

The authors advocate that researchers engage early with all stakeholders to avoid later criticism and early closure of trials. Activism has an important role in ensuring that researchers and sponsors maintain ethical standards and adapt trials as new ethical concerns emerge. In the trials discussed in this article, researchers tried to, but did not, reach all activist communities. This happens frequently, and those who are excluded became hostile. The authors suggest strategies to avoid such an event.

Mills EJ et al. Designing research in vulnerable populations: lessons from HIV prevention trials that stopped early. *BMJ* 2005;331:1403-1406.

The authors report that based on their survey of data from 21 member countries of the Organization for Economic Cooperation and Development, about 50 per cent of countries had inequities in patients' use of specialist services. Although in most OECD countries general practitioner care is distributed fairly equally and is often even pro-poor, the presence of private insurance or private care options in the health care system tend to make total doctor utilisation biased in favour of the rich.

van Doorslaer E, et al. Inequalities in access to medical care by income in developed countries. *CMAJ* 2006; 174: 177-183.

Forget the suits and smile instead of frowning

To determine if doctors' dress styles and modes of address affect patients' perception of doctors, the authors conducted a descriptive survey of over 500 outpatients and inpatients in New Zealand. They found that patients preferred doctors to wear semiformal attire, in general conservative items. But they also noted that patients preferred smiling face even more, suggesting a friendly manner may be more important than sartorial style. Patients also preferred that doctors should introduce themselves fully and clearly, and they should identify themselves by a name badge worn at the breast pocket.

Lill MM, et al. Judging a book by its cover: descriptive survey of patients' preferences for doctors' appearance and mode of address. *BMJ* 2005; 331:1524-1527.

Stop HIV with traditional disease control practice

Controlling epidemics is a fundamental responsibility of the government, working in concert with physicians, patients, and communities. There is a delicate balance between the public's protection and the individual right to privacy. The authors argue that a comprehensive public health approach was not used in the USA to stop the HIV epidemic for fear of discriminatory practices against stigmatised populations. It is necessary to adopt traditional disease-control principles and proven interventions that can identify infected persons, interrupt transmission, ensure treatment and case management, and monitor infection and control efforts throughout the population. The authors acknowledge the political and economic costs of such an action but argue that until these measures are adopted the spread of HIV infection cannot be reduced.

Frieden TR, et al. Applying public health principles to the HIV epidemic. *N Eng J Med* 2005; 353:2397-2402.

Private care at the public's expense

The authors bemoan the expansion of the private health care sector, a mere 5-10 per cent at independence, to the current

82 per cent of all health care. This expansion of private sector has been deliberately encouraged by the government through various means such as granting land for private hospitals at a fraction of the cost, reducing duties on imported medicines and machines, and so on. Most private health care is paid for with personal funds, causing great hardship to individuals. Despite this, patients shun public hospitals as they are understaffed, under-provisioned and unsanitary. The authors suggest that corrective measures should include greater social accountability of private providers, making a certain proportion of private services available to the poor, and an increase in public expenditure on health care with a health insurance scheme for poor families.

Sengupta A, Nundy S. The private health sector in India: is burgeoning, but at the cost of public health care. *BMJ* 2005; 331:1157-1158

Other views on the private-public debate

The article by Sengupta and Nundy drew a number of responses. Some of these are summarised here. A private consultant from Kolkata points that defense spending has grown since independence but we don't say that this is at the cost of public health care, so it is unfair to blame private care for the decline of public care. When we speak of levying a tax on private patients, Indian or foreign, to go into a "fund for the poor", we are asking private health care to assume the government's role which is providing health care for the poor.

A consultant from Mumbai agrees that public health needs more funds but he feels that they will not be generated by holding back the development of private health care. Instead he suggests that a portion of the foreign exchange earned through medical tourism, a new source of national income, be channeled into primary health care.

An Indian working in Australia writes that rather than blame the private sector it should be improved through better regulation and asked to participate in providing care for the poor. He reminds private health sector CEOs that they need to abstain from profiteering.

Finally, an Indian working in Canada asserts that universal health care is the best option. He points out that unless the wealthy use the public health system and are inconvenienced by its shortcomings, the public health infrastructure will not improve.

Bose A. Private health sector in India: is private health care at the cost of public health care? *BMJ* 2005;331:1338-1339.

Rajan TD. Private health sector in India: let's not confuse the issues. *BMJ* 2005;331:1339

Bal Abhijit M. Private health sector in India: Line between profit and profiteering is often thin *BMJ* 2005;331:1339

Bagchee S. Private health sector in India: Single level health care is the only solution. *BMJ* 2005;331:1339

Editorial freedom

This *CMAJ* editorial outlines the circumstances behind the incident of editorial interference by CMA at CMAJ. CMAJ has strongly objected to this and hopes that by going public with this incident, further interference will be prevented.

Editorial. The editorial autonomy of *CMAJ*. *CMAJ* 2006; 174: 9.

Recruitment of a sufficient number of participants is essential for the successful completion of a randomised controlled trial. One strategy to increase recruitment to trials is to pay health care professionals to recruit subjects either by providing financial incentives or by reimbursing the excess costs incurred. This is uncommon in publicly funded, but not privately funded, research. One question to ask is: how often does financial incentive increase recruitment? The authors searched for research on this topic and could not find sufficient studies in electronic databases from their inception till 2004. They comment on why this is an important research topic.

Bryant J, et al. Payment to healthcare professionals for patient recruitment to trials: a systematic review *BMJ* 2005;331:1377-1378

Measuring professional behaviour

This editorial reflects on an article by Papadakis et al (2005; 353: 2673-2682) in the same issue, which makes the case that the unprofessional behaviour of medical students can lead to their unprofessional behavior as practising physicians. It is relatively simple to devise a curriculum and judge the adequacy of a person's knowledge. Professionalism is most difficult to measure. The medical profession, especially medical educators, cannot wait until optimal data and resources are available to teach and assess professionalism in medical students.

Kirk LM, et al. Professional behavior — a learner's permit for licensure. *N Eng J Med* 2005; 353:2709-2711.

Publicising clinical trial results

The authors propose that the current demand for the public registration of all clinical trials at their inception must include a demand for the addition of all results after each trial is completed and after a certain amount of time has elapsed for publication of data. This will ensure that negative trial results or unwelcome outcomes will also become known.

Haug C, et al. Registries and registration of clinical trials. *N Eng J Med* 2005; 353:2811-2812

Renewing certification

In the USA, specialty board certification is voluntary, under the regulation of American Board of Medical Specialties (ABMS) and till now certification was for life. Systematic reviews have shown that the quality of physicians' performance decreases as the number of years in practice increase. So, in response to public pressure, in 2005 ABMS decided to issue only time-bound certification, which will need to be renewed every 10 years following a recertification exam or a "maintenance of certification", a more continuous process of assessing competence.

Steinbrook R. Renewing board certification. *N Eng J Med* 2005; 353:1994-1997.