# FROM OTHER JOURNALS

*We scan the* Annals of Internal Medicine *(www.annals.org),* New England Journal of Medicine *(www.nehm.org),* Lancet *(www.thelancet.com),* BMJ *(www.bmj.com),* Journal of Medical Ethics *(http://jme.bmjjournals.com), and* Canadian Medical Association Journal *(www.cma.ca/cmaj.com), for articles of interest to the medical ethics community. For this issue of the* IJME *we reviewed the November 2005 - January 2006 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.*

## Can publishers afford to provide free access?

Electronic publishing, beginning in early 1990s, has improved access to scientific literature through the internet. Some advocate a totally free access to all scientific literature. However, the author, while endorsing the principle of free access to science, argues that we should take into account the cost to the publisher. These costs are traditionally recovered through institutional subscriptions, advertising, fees for author submissions, etc. If scientific articles are available online within six months of publication, publishers would lose their revenue stream and would have to move to an author-pay publishing model which would prevent a significant number of authors from publishing their data.

**Frank M. Access to the scientific literature – a difficult balance. *N Engl J Med* 2006; 354:1552-1555.**

## The right not to be vaccinated

The success of vaccine-induced immunity has been immensely beneficial in preventing epidemics. In order for vaccines to be truly effective, a majority of the people have to be vaccinated, which has led to some countries such as the USA and Australia making it compulsory. Some, experts and lay people, believe that people should be allowed to opt out if they choose to do so. The authors discuss the pros and cons of this course of action.

**Salmon DA, Teret SP, MacIntyre CR, Salisbury D, Burgess MA, Halsey NA. Compulsory vaccination and conscientious or philosophical exemptions: past, present, and future. *Lancet* 2006; 367:436-442.**

## The right not to treat

Conscientious objection is that which is based on deeply-held religious or secular beliefs. While religious or secular beliefs may conflict with medical practice this does not allow the doctors to make moral judgments on behalf of patients and deny them treatments to which they are entitled by law. The author firmly states that conscientious objection is wrong and immoral as the patient's good and the patient's informed desires should be paramount as long as they are in accordance with the law. He acknowledges that moral values are very important but he feels that they must be restricted to the personal sphere. He allows that there are some exceptions, such as, for example, end-of-life issues or termination of a late pregnancy where the law is unclear. In that case a doctor should explain the situation as clearly as possible to the patient and give a referral to another for a second opinion. The author advocates disciplinary action against those who compromise the care of the patient.

**Savulescu J. Conscientious objection in medicine. *BMJ* 2006; 332:294-297.**

## Corruption and public health care

The writer describes the condition of Romania's health system which has been on the verge of collapse due to its fiscal problems. Despite paying 13.5 per cent of their income as health insurance, which should entitle them to free treatment for any medical condition, patients are asked to get not only medicines but their own food and linen to the hospital. Corruption is ingrained and patients have to pay bribes for everything. Observers say that until the rampant corrupt practices are rooted out no amount of money that is put into the health system will improve patient care.

**Ionescu C. Corruption targeted in Romania's health reforms. *Lancet* 2006; 367: 1307-1308.**

## Genetic discrimination

The writer reports on the experience of a job applicant to illustrate the consequences of genetic testing. A teacher interviewed for a job in Germany disclosed, during her pre-job medical evaluation, that her father had Huntington's Disease. She herself had refused genetic testing though she knew that she had a 50 per cent chance of developing the disease at some point in her life. She was refused the job on the argument that she might have become irregular in her work attendance in the future if she manifested the disease. The author discusses the ethics of a medical evaluation which includes both a medical history and a family medical history. The author proposes that there are two forms of discrimination. Discrimination on the basis of race or sex is described as primary discrimination which is unacceptable. Secondary discrimination does not have clear limits on what is morally unacceptable. Nobody would consider the teacher to be less worthy than other human beings because of her higher genetic risk. However, she has a higher risk of future absenteeism and it is not irrational to base unequal treatment on this. In contrast to primary discriminations, these secondary forms do not offer a clear limit to what is morally unacceptable. Rather, these limits must be the result of agreements which are constantly subject to discussion and changes within a society.

**Schmitz D, Wiesing U. Just a family medical history? *BMJ* 2006; 332:297-299.**

## The stories behind research fraud

The author discusses the recent cases of research fraud by Dr Hwang and Dr Sudbo and suggests mechanisms to detect and prevent such fraudulent publications, paying particular attention to the participating co-authors who benefit from the

publication but pay little penalty for the fraud committed by the principal author.

**Gerber Paul. What can we learn from the Hwang and Sudbø affairs? *Med J Aust* 2006; 184: 632-635.**

## The organ trade is international

This editorial discusses the law passed by China, effective July 1, 2006, forbidding the buying and selling of organs. Until this time, "transplant tourism" has flourished in China as wealthy patients from around the world came to China for organs they desperately needed for survival. Many of the organs transplanted are believed to have come from executed prisoners, though the Chinese have steadfastly denied this charge. The new law should also encourage other countries such as Romania and Nigeria to ban the trade in organs.

**The Lancet. Editorial. Not for sale at any price. *Lancet* 2006; 367: 1118.**

## Compensation for injury in research

The author, representing a network of researchers in South Africa, advocates a change in the current policy of the US National Institutes of Health and Centers for Disease Control. This policy states that while subjects will receive treatment for a research-related injury, they will not receive any additional compensation. This rule is not only for research conducted in South Africa but applies to all studies, including domestic research. The author feels that an exception should be made when the population that is being studied is in a developing country and vulnerable due to poverty.

**Cleaton-Jones P. Research injury in clinical trials in South Africa. *Lancet* 2006; 367:458-459.**

## Sharing research findings

Research participants are eager to learn of the results of the study that they participated in. However the process of sharing research outcomes is not simple. A participant who is unable to understand the nuances of the research study may react negatively to the results. A simple summary of results may not satisfy participants who may wish to know about their individual results. Therefore the sharing of results needs careful planning.

**The Lancet. Editorial. Trialists should tell participants results, but how? *Lancet* 2006; 367:1030.**

## The TGN1412 mishap

The author reflects on the lessons learned after six healthy volunteers participating in TeGenero's TGN1412 Phase I trial developed life-threatening adverse events. The regulation of clinical trials has been under review. There was no evidence of a problem with the test drug's quality, no contamination, no dosing error, and "it was run according to the agreed protocol". Since it is difficult to predict in humans from animal studies, when novel molecules are used, the author suggests that it is important to test new drugs on just one volunteer and observe the response before proceeding to larger numbers in Phase I trials.

**The Lancet. Editorial. Urgent changes needed for authorisation of phase I trials. *Lancet* 2006; 367: 1214.**

## Why doctors kill

This essay looks at the controversial history of physician participation in capital punishment. The American Medical Association specifically prohibits physicians from participating in the execution of prisoners. The courts have struggled with carrying out execution humanely, protecting the prisoner from cruel and unusual punishment. Death by firing squad, hanging and electrocution were all found unconstitutional on this basis. The only method felt to be appropriate was death by lethal injection. The precise methodology was devised by an anesthesiologist in 1980 and since then doctors have come under increasing pressure to participate in executions. Physicians and nurses employed by the prison system have the option of refusing to participate. The author interviewed five medical personnel who have taken part in lethal injections. While each story is different, the common thread appears to be that physicians get sucked into the execution system after getting involved in ways that they believed to be helpful. Over time, their involvement escalates and they play critical roles in the procedure. Some of them participate in executions because they feel that they must provide competence and comfort to those who are in their care. While acknowledging that there is some force in this argument, the author comes out strongly against physician participation saying: "a society in which the government actively subverts core ethical principles of medical practice is patently worse off for it. The government has shown willingness to use medical skills against individuals for its own purposes; having medical personnel assist in the interrogation of prisoners; place feeding tubes for force-feeding them, and help with executing them. As medical abilities advance, government interest in our skills will only increase. Preserving the integrity of our ethics could not be more important….. The easy thing for any doctor or nurse is simply to follow the written rules. But each of us has a duty not to follow rules and laws blindly."

**Gawande A. When law and ethics collide – why physicians participate in executions. *N Engl J Med* 2006; 354:1221-1229.**

## The role of the informal health worker

The author contends that family members, community leaders and shopkeepers work as informal health workers wherever the formal health-care system is weak or overwhelmed by the numbers of patients. This is true in many countries in sub-Saharan Africa which are dealing with AIDS. He would like to provide more health information and training to such people rather than frown on their participation. He also recommends increasing the level of health information in the general population so that people themselves can discern good from bad advice given by such informal workers.

**Omaswa F. Informal health workers – to be encouraged or condemned? *Bull World Health Organ* 2006; 84: 83.**

## Medicine as a professional enterprise

The authors discuss the deterioration in medical ethics where profits seem to come before patient welfare. They acknowledge that it is not sustainable to focus on patient welfare alone without generating profit for the practising physician. They propose that medicine should become a patient-centred professional enterprise with ethical business practices.

**Singh AR, Singh SA. Medicine as a corporate enterprise, patient welfare centered profession, or patient welfare centered professional enterprise? *Mens Sana Research Foundation* monograph series 2006; 3 (4-5): 19-51.**

### The INN system

This editorial supports the international campaign for international non-proprietary name drugs. In 1950, the World Health Assembly asked the WHO to develop the INN system, to name drugs in such a way that they would be recognised and pronounced correctly anywhere in the world. An editorial reproduced from *Prescrire International* notes that the INN system is "another means of providing patients with sound, honest information, of explaining why a specific drug treatment has been chosen, and any monitoring that is needed… It makes things clearer for everyone, helps to rationalise drug use, reduced waste and prevents confusion and accidents."

The BODHI editorial suggests that arguments against the INN system are essentially in support of irrational and unethical practice. "A suspicion of an underlying system of give and take between the prescriber and the producer cannot be ruled out."

**Editorial. Let's join the global campaign. *BODHI* 2006; 13 (1): 1-2.**

### Will international accreditation benefit Indian patients?

This columnist reports on the growing trend of Indian hospitals to apply for accreditation by the Joint Commission International Accreditation of Health Care Organizations (JCIA), as part of the efforts to promote themselves as destinations for medical tourism. Some new standards will definitely help patients and health care personnel – hepatitis B immunisation, universal precautions and responses for needlestick injury, documentation, and so on. However, the author suggests, some changes will only push health care costs up further, with no real benefit for the Indian patient. Some examples: replacing all mercury-based thermometers and blood-pressure equipment, replacing the resin-based deioniser used in dialysis with a membrane deioniser, and doing away with formaldehyde as a sterilising agent. "The state of the art is not compatible with the state of our purse. Can we not adopt all that is good and within our financial capacity in the JCIA recommendations, and put on hold those that will cost too much? We will not get the coveted imprimateur of the JCIA, but the average Indian will be able to come to us for treatment."

**Mani MK. Letter from Chennai. *Natl Med J India* 2006; 19: 44-5.**

## CORRESPONDENCE

### The essence of the 'art' of medicine

The article by Neha Madhiwalla and Nobhojit Roy (1) is a timely analysis of the growing attacks on doctors and hospitals, mainly in Mumbai. The authors identify the lack of communications skills in trainee doctors, especially in sharing bad news, as one of the main factors. This clearly points to the need for communication skills to be included in the medical training given to students.

It is common practice in western medical and dental schools to teach students how to handle difficult situations with patients and their families. An example is the Schulich Medical and Dental School's clinical skills programme in Ontario, Canada (2). The programme uses "standardised patients" to train and evaluates the students on how they handle various simulated situations.

The Medical Council of India recently announced plans to revise the MBBS curriculum and include communication skills as part of first-year training (3). The proposed changes have been sent to state governments for comment. As planned, medical education units in colleges, often defunct, should be given the responsibility of organising training in skills for communicating with patients and relatives. This would also help in dealing with patient perceptions, a need highlighted by Sunil Pandya in a 2001 editorial (4).

A lot of medical training and the way we learn to interact with patients come from observing peers and seniors. During my training, the most popular clinical faculty members and the ones with the longest queues at the out-patient department were not necessarily the ones who were the best technically, but the ones who were congenial and interacted with patients in a respectful manner. That for me was the essence of the "art" of medicine.

Many other factors have led to the rising violence in medical settings, as highlighted in the article, including a lack of infrastructure and frequently malfunctioning equipment, as was evident in the recent problems with the morgue cooling plant in Sassoon Hospital in Pune (5). This is an example of a situation that can lead to anger and provoke violence among waiting and grief-stricken relatives.

It would have been interesting to study whether there is any difference in the responses gathered at teaching hospitals as compared to peripheral hospitals. More space could also have been given in the article to the perceptions of patients. The article should provoke critical thinking among all of us, but especially among hospital administrators and medical college deans.

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