Caesareans on demand?

■ These two essays discuss a question doctors seem to be facing in the West, where the risks of elective Caesarean sections are falling and vaginal delivery is perceived to have many risks or inconveniences. How should doctors respond when a woman asks for an elective C-section?

The first essay argues that a informed woman's choice to have the procedure must be respected, even if the health provider disagrees. When one-third of female obstetricians in the West would choose a prophylactic caesarean section for themselves, the procedure can no longer be considered clinically unjustifiable; it's part of accepted medical practice there.

The second essay points out that many women have misconceptions about the potential discomforts and risks of a vaginal delivery as opposed to a c-section; further, the operation has its risks, however low they can get. The conflict is between patients' rights to make autonomous decisions and carers' right to autonomy in operating according to accepted medical practice. While there are few justifiable constraints on women's choice, the choice needs to be informed. Doctors, midwives, and childbirth educators must give full and honest advice based on the available information; they may persuade but never coerce.

Should doctors perform an elective caesarean section on request? Education and Debate. ***BMJ*** **1998; 317: 462-465**

Masked monitoring in clinical trials

■ Neither participant nor investigator is supposed to know which treatment a particular patient is getting in a randomised clinical trial, in order to eliminate treatment-bias.

However, a monitoring committee reviews interim results; if a significant difference between treatments emerges, it halts or modifies the trial so that one group does not get a clearly inferior treatment.

Sometimes these committees get masked data: results presented in code which don't let on which results belong to which group. While this is meant to aid objectivity, it may actually deny the monitors information needed to perform competently, and can pose a risk to the subjects. The requirement of competency takes precedence over the desire for objectivity when research involves human subjects.

Also, a prudent monitoring committee will want to know if the difference can be explained away. Masked analyses are unfocused and inefficient, and it is difficult to get masking lifted on request.

Sophisticated monitors can also break the code on the basis of telltale treatment side effects, resulting in speculation — and a contorted dialogue — since the speculation cannot be made public.

Randomised treatment trials *must* be monitored, if not by investigators then by fully-informed monitoring committees that perform in accordance with ethical principles and to the satisfaction of institutional review boards. Committee members should have the necessary expertise and be free to act without constraint. The drive for objectivity should not lead to triple-masked trials, in which neither patients nor investigators nor monitors know what's going on.

Meinert, CL. Masked monitoring in clinical trials — blind stupidity? ***New England Journal of Medicine*** **1998; 338**

Question of brain death

■ With the introduction of the neurological definition of, and criteria for, death in the 1960s, transplant centres in the West focused on donations from heart-beating cadavers. By the early 1990s, in response to the increasing shortages of organs for transplant, these centres reconsidered the use of 'controlled non-heart-beating' donors. Ethical questions were raised following reports of improper treatment of donors, specifically, antemortem recovery of organs and administration of drugs that allegedly might hasten donor death.

In these circumstances, the US department of health and human services commissioned a report to develop guidelines for a good and morally justified organ donor and transplantation programme. It asked: Given a potential donor (severely ill or injured but not brain dead) in an end-of-life situation, what medical approaches should be used to maximise the availability of organs from that donor without violating ethical norms?

This report notes considerable variation in organ procurement practices across the the US, and suggests that all work be based on certain fundamental scientific and ethical principles. It recommends that programmes pay particular attention to potential conflicts of interest. It also sets some standards: patients must be dead when organs are removed, not killed by donation; there should be complete openness of policies and protocols, a commitment to informed consent, attention to conflicts of interest, and respect for the donor's and family's wishes.

The report also addresses and makes recommendations on issues such as: the use of drugs and techniques beneficial to organ quality but useless and possibly painful to the donor; standards of determination of death, technologies for monitoring heart function; the conflict between the doctor's need to confirm death andthe transplant team's need to get an organ;and the need to protect and respect donor families.

Herdman R, Beaucham TL, Potts JT. The Institute of Medicine's report on non - heart - beating organ transplantation. ***Kennedy Institute of Ethics Journal.*** **1998; 8 (1): 83-90.**

Changing laws on abortion

■ The legal status of induced abortion helps determine the availability of safe, affordable abortion services in a country, which in turn affects maternal

mortality and morbidity. Abortion-related laws in 152 nations and dependent territories were reviewed and changes since 1985 documented. Currently 61 per cent of the world's people live in countries where induced abortion is permitted for a wide range of reasons or without restriction as to reason. In contrast, 25 per cent live in countries where abortion is generally prohibited. However, even where there are highly restrictive laws, it is usually permitted when the woman's life is endangered. And where there are liberal laws, it may be restricted in terms of gestational age, third party authorisation, types of legal facilities. Since 1985, 10 countries have significantly liberalised their abortion laws; only one country has substantially curbed legal access to abortion. The conclusion: a global trend towards liberalisation of abortion laws started before 1985 has continued. Still, women's' access is affected not only by the laws but also by how they are interpreted, enforced, and the medical community's attitudes.

Rahman A, Katzive L and Henshaw SK. A global review of laws on induced abortion, 1985-1997. ***International family planning perspectives.*** **1998; 24: 56-64.**

Pharmaceutical industry support for CME

■ In this review of current ethical guidelines for pharmaceutical industry support for continuing medical education programmes, the author notes that the relationship has been the subject of concern to many involved in medical education and medical journalism. Guidelines are needed to maintain the integrity of the medical profession, failing which distinctions between advertising, promotion, information and education are blurred. Estimates of drug companies' expenses for CME range from $2.5 billion to $10 billion, including leisure trips.

References is made to statements of the World Health Organization (objective scientific content should be paramount), the British Medical Association (okaying inexpensive promotional gifts relevant to medical practice), the Royal College of Physicians ("any benefit...must leave the doctor's independence of judgement manifestly unimpaired"), the American Medical Association, the Canadian Medical Association, the US Accreditation Council for Continuing Medical Education, the American College of Physicians and the Food and Drug Administration and other organisations. "The common features of nearly all the guidelines is that the CME sponsors, not the drug industry or the funding source, should be responsible for the content and quality of the CME programme, that the funds should be given in the form of an unrestricted educational grant to the CME sponsoring organisation, and that financial arrangements and any possible conflict of interest be disclosed."

Rosner, F. Pharmaceutical industry support for continuing medical education programs: A review of current ethical guidelines. ***The Mount Sinai Journal of Medicine.*** **1995; 62: 427-430.**

What do doctors really think about euthanasia?

■ In order to get a national picture of what US physicians thought about physician-assisted suicide and euthanasia. This study reports on a questionnaire mailed to a sample of 3102 physicians in the 10 specialties most likely to receive such requests, and weighted the results for nationally representative data. Based on a 61 per cent response rate, 11 per cent said there were circumstances in which they would be willing to hasten a patient's death by prescribing medication, 7 percent said that they would provide a lethal injection. However, 36 percent and 24 percent respectively, said that they would do so if it were legal. Still, about 6 percent complied with such requests at least once.

Meier Diane E., Emmons Carol-Ann, Wallenstein Sylvan, Quill Timothy, Morrison R. Sean, Cassel Christine K. A national survey of physician-assisted suicide and euthanasia in the United States. ***The New England Journal of Medicine.*** **1998; 338: 1193-1201**

Cultural relativism?

■ What one group believes is a necessary practice, another holds is a human rights violation. How is the medical professional to resolve the dilemma? The multi-cultural composition of societies can pose such problems for physicians and patients who come from diverse backgrounds. The author argues that although respect for cultural diversity mandates tolerance of the beliefs and practices of others, in some situations excessive tolerance can produce harm to patients.

The author calls for careful analysis to determine which values are culturally relative and which rest on an underlying universal ethical principle. A conception of justice as equality challenges the notion that it is always necessary to respect all of the beliefs and practices of every cultural group.

The discussion includes a number of case studies to illustrate these points: an African parent who wants the doctor to perform genital surgery on her daughter; the Navajo patient for whom information about a procedure's risks is tantamount to provoking the harm itself; the Laotian mother who branded her baby for her health.

Macklin Ruth. Ethical relativism in a multicultural society. ***Kennedy Institute of Ethics Journal.*** **1998; 8 (1): 1-22.**

The ethics of cancer research

■ A special issue of *The Ecologist* on cancer (Cancer: are the experts lying?) mentions a recent article in the *New England Journal of Medicine* which looked into the influence of funding on scientific and medical opinions and revealed a disturbing if unsurprising fact: the views of the specialists were likely to be heavily influenced by the source of their

funding. A survey of 86 medical experts who had written on the use of calcium-channel blockers — controversial drugs used to treat patients suffering from high blood pressure and heart disease — found that 96 per cent of those in favour of the drugs had financial relationships with the manufacturers; 37 per cent against the drugs had links to the companies; and 60 percent of those neutral had links. For its part, the *NEJM* carried an attack on Sandra Steingraber's book *Living Downstream: an Ecologist Looks at Cancer.* The book had otherwise received positive reviews for its "clear discussion of environmental contaminants and their links to cancers". The reviewer:the director of toxicology for WR Grace, a major chemical manufacturer. The journal did not the reviewer's affiliations, though he did so to the journal.

The cost of objectivity. *The Ecologist.* 1998; 28 (2). Campaign and news.

Role of medical ethics in torture cases

■ This article reviews the medical ethics issues concerning torture with special reference to declarations, principles and guidelines applicable to medical professionals. Two illustrative cases brought for autopsy are cited.

Kohli A, Aggarwal N , Murty OP. Role of medical ethics in torture cases with two illustrations, *Journal of Forensic Medicine and Toxicology*, 1997,14:41-46.

Via the internet:

The Council of Europe's case-study-based review of the human rights, ethical and moral dimensions of health care with examples relating to genocide, torture, inhuman treatment, abusive psychiatry and application of penalties by doctors. 500 pp. 240 French Francs/ US$ 60. Contact: mailto:publishing@coe.fr or visit: http://book.coe.fr

The WHO Report of the Informal Consultation on Health and Human Rights which took place on December 4-5, 1997 (WHO/HPD/98.1) is uncatalogued but available from the Office of Health Policy in Development at WHO, Geneva. http://www.who.int

The American Association for the Advancement of Science issues actions on behalf of imprisoned scientists via a listserver. To subscribe, e-mail mailto:majordomo@aaas.org with the message subscribe aaashran <your name> An archive: http://shr.aaas.org/aaashran.htm

The International Federation of Red Cross and Red Crescent Societies weekly newsletter mail to: <listproc@ifrc.org> putting the following text in the body of the message: subscribe wne-dist YOUR NAME

The Mail and Guardian (Johannesburg) reported on March 30, 1998 that the South African Truth and Reconciliation Commission (TRC) would name 35 doctors accused of human rights violations during the apartheid era. The story can be found at:<http://www.mg.co.za/news/98mar2/30mar-trc_doctors.htm> The TRC website: http://www.truth.org.za/. Register on-line to receive regular e-mailed bulletins and press statements from the TRC.

The Geneva Initiative on Psychiatry announced on April 3, 1998 the formation an Association of Reformers in Psychiatry (ARP). This followed a meeting in the Netherlands on April 2 of the Network of Reformers in Psychiatry. See: http://www.colorsoflife.nl/geneva-initiative/visitors.htm

***Issues in Medical Ethics* can also be seen on the internet, at:**
http://www.helplibrary.com/reading/ethics/index.htm.

CALENDAR

November 4-7, 1998. Tokyo, Japan: Fourth world congress of bioethics. International Association of Bioethics (IAB4) in conjunction with the Asian Bioethics Association. Global bioethics. East and West, South and North. with satellite meetings from October 31. Applications for fee waivers or grants will be considered.
E-mail: kasamatu@chs.nihon-u.ac.jp. http://www.biol.tsukuba.ac.jp/'macer/IAB4.html

November 7-10, 1998. San Diego, CA, USA: meetings of the Public Responsibility In Medicine and Research (PRIM&R) and Applied Research Ethics National Association (ARENA). Nov 7: 'IRB 101'. An overview of IRB regulations and policies. Nov 8-9: 'IRBs in the shifting sands of public opinion.' Annual IRB meeting of PRIM&R. November 10: IRBs: motivating for change. Annual IRB meeting of ARENA, focusing on practical and innovative solutions for institutional review boards. Contact: (617) 423-4112. E-mail prmr@aol.com. Internet: http://www.aamc.org/research/primr

November 28-30, 1998. Mumbai, India: Preventing violence, caring for survivors: The role of the health profession and health services in violence. Centre for Enquiry into Health and Allied Themes. Contact: CEHAT (91 22) 625 0363. Fax: (91 22) 620 9203. E-mail : admin@cehat.ilbom.ernet.in

December 3-4, 1998. Hertogenbosch/ Vught, Netherlands: Psychotrauma/ asylum seekers/refugees: pitfalls in treatment, political and judicial context". Contact: Nicole van de Gevel, Secretary. Fax: +31 73 658 5502

June 5-6, 1999. Istanbul, Turkey: The European Society for Traumatic Stress Studies 6th European Conference on Traumatic Stress "Psychotraumatology: Clinical Practice and Human Rights". Contact: Interium, Birlik Sokak, Akyildiz Sitesi, No. 24/B D7, 1 Levent, Istanbul, Turkey, Tel: +90 212 264 3770, Fax: +90 212 280 3961, E-mail: interium@turk.net