Ethics and the medical student

■ What does the medical student understand by the word 'bioethics'? This survey of 125 first-year students in the All India Institute of Medical Sciences and the University College of Medical Sciences found a good deal of ignorance on the subject, compared to, for example, a subject such as AIDS. Still, many students had strong opinions on subjects such as acceptance of gene therapy and other scientific developments. The authors conclude that students feel the need for ethics related education. Such an education should exist at various levels, including bioethics education at the college level and beyond. "… many students are not comfortable with the concepts that are very important for the development of professional health care workers and scientists who will be faced with moral dilemmas in their daily work after graduation."

Dhar Pusha, Macer Darryl: Views of Indian medical students on bioethics and the teaching of ethics. *Eubios Journal of Asian and International Bioethics* 2001; 11: 78-82.

Medical practice in south Asia

■ This physician trained in the US describes the lessons learned through encounters with patients while practising in Pakistan. "In Pakistan, as in many non-Western cultures, decisions about a patient's health are often made by the family or the doctor. ...the Pakistani approach requires striking a balance between preserving indigenous values and carving out room for patients to participate in their medical decisions." The importance of religion, the respect given to the physician, the conflict between the family as the fundamental social unit and economic realities, the importance of beneficence and non-maleficence rather than patient autonomy — sensitive physicians must take into account such issues as part of their practice.

Moazam Farhat: Families, patients and physicians in medical decisionmaking: a Pakistani perspective. *Hastings Center Report* 2000; 30: 28-37.

Authorship

■ This essay on publishing ethics covers details such as the need to define authorship, multi-centre studies, student-faculty studies, acknowledging support, rights and responsibilities of authors, and an evaluation of guidelines on authorship. The writers conclude: "…in spite of the rules, regulations and recommendations, … It is only the authors whose principled behaviour can give these guidelines some meaning… manuscripts should be written to become a record of discovery, not just a curriculum vitae for every working scientist."

Sahu DR, Abraham P: Authorship: rules, rights, responsibilities and recommendations. *Journal of Postgraduate Medicine* 2000; 46: 205-210.

Brain death

■ With increasingly sophisticated life sustaining techniques, the determination of death can be a very specialised task today, going beyond measuring heartbeat and breathing. Standards for diagnosing death using brain-based criteria are widely accepted internationally. Still, discussions on 'brain death' are filled with 'metaphysical, cultural, legal, and medical controversy'. The reason: a lack of precision reflects conceptual confusion on the part of medical and professionals, and creates it in the minds of the public.

"Since 'brain-dead' patients show such traditional signs of life as warm, moist skin, a pulse, and breathing, it is not surprising that many people seem to think that 'brain death' is a separate type of death that occurs before 'real' death." This confusion is reinforced when doctors speak of 'life support' being removed from such patients, and when judges state: "When the life-supporting measures were suspended, death ensued [although the person] was legally dead even before heroic life support procedures were discontinued."

Ongoing debates on defining death according to loss of function of the 'higher brain' death as opposed to the 'whole brain', and challenges to this concept of death on medical grounds, further confuse the issue.

The notion that brain death is different from ordinary death continues to affect policy debates, perplexing the public and also leading some to believe that they can choose between different standards of death. This last suggests that the definition is purely utilitarian, and naturally contributes to people's ambivalence about organ donation.

The writer concludes that physicians applying current standard criteria and tests for determining death should be very clear about the 'conceptual foundations of the definition they are implementing'. They should 'avoid terms such as "brain death" and allow families time to understand the basis of a diagnosis of death that is not self-evident when the respirator-supported body of their loved one manifests many outward signs of life.'

Capron Alexander Morgan: Brain death — well settled yet still unresolved *The New England Journal of Medicine* 2001; 344 (16)

Equal access with resource constraints

■ A recent UK inquiry report charged that children with Down's syndrome were discouraged from necessary cardiac surgery, and recommended that the profession should ensure that people with disabilities have equal access to care on the basis of need. This provocative editorial challenges the assumptions of the inquiry report. Though both UK law and the European Convention on Human Rights will hold such practices unlawful, decisions to provide care with limited resources will definitely measure the relative improvement in quality of life. Such decisions are taken routinely, for example when deciding not to transplant for a person with brain injury or dementia, on the basis that scarce organs would do more good for people without such impairments. The equality of access principle would give equal right to both patients; but the quality of life principle will give priority to the patient who will benefit most. "We should face reality: quality and length of life and probability of benefit (and cost of treatment) are relevant in determining who should receive treatment. Severe disability in some circumstances should disqualify a person from access to scarce resources."

"Down's syndrome is associated with intellectual disability, infertility, reduced opportunities for independent living and employment, shorter life, and early onset Alzheimer's disease." The author concedes that considerable variation exists in the quality of life of people with disability for which reason every case for heart transplantation should be judged on its merits, assessing all factors, but "including the likelihood of a good outcome."

Of course the better alternative is to increase health expenditure and improve organ donation rates. "One terrible constraint that forces us to decide between people would then be removed."

Savulescu Julian: Resources, Down's syndrome, and cardiac surgery: Do we really want 'equality of access'? Editorial *BMJ* 2001;322:875-876

Reacting to a medical error

■ When the junior doctor realises that his failure to read a patient's ECG resulted in the patient's death, he went directly to the consultant — who falsified records to cover up the truth. A doctor describes his first, tragic medical mistake 15 years earlier, and how his senior covered it up. He reflects on the need for medical audit, and the benefits and harms of publicising the mistake to the individual family, the junior doctor and the medical system as a whole.

"The publication of every medical mistake may cause widespread harm and result in a mistrust of medicine. This does not mean that serious errors should be routinely and uncritically swept under the carpet. However, a first occurrence is probably best seen as an opportunity for education not litigation. In the long term such a course may help make us more careful and considerate physicians."

Three commentaries highlight the dangers of cover-ups— procedural and systemic problems which led to the error are not addressed; the trust between physician and patient is breached, and doctors learn to cover up mistakes instead of taking responsibility for them and learning from them.

Singer P A, Wu A W, Fazel S: Education and debate Medical errors and medical culture An ethical dilemma *The New England Journal of Medicine* 2001; 344 (15)

The condolence letter

■ When a patient dies, do Indian doctors even dream of sending a condolence letter to the family? The writers suggest that a " physician's responsibility for the care of a patient does not end when the patient dies. There is one final responsibility — to help the bereaved family members. A letter of condolence can contribute to the healing of a bereaved family and help achieve closure in the relationship between the physician and the patient's family."

However, doctors are either too busy, or they otherwise feel uncomfortable with the idea of writing such letters, though the physician's was much more intimately part of the mourning process in earlier days.

"The doctor's role at the time of mourning has also become more distant and less supportive. Physicians are not trained to support a bereaved family."

Such actions especially help families cope with the anger of unexpected death, and their absence can provoke suspicion. They also help the physician experience a sense of closure. They also serve as a model for other staff.. The writers see writing condolence letters as a professional responsibility, and offer suggestions on how to write one.

Bedell Susanna E, Cadenhead Karen, Graboys Thomas B: The Doctor's Letter of Condolence *BMJ* 2001;322:1236-1240

The conjoined twins

■ The UK courtroom battle last year between the parents of conjoined twins and their doctors illustrates "the difficulty of applying legal principles to unprecedented life-and-death decisions involving proposed medical interventions for children — particularly when parents and physicians disagree about what should be done."

The twins' parents, who are Roman Catholic, came to England for medical care when the mother was pregnant and tests showed the twins were conjoined, in the hope of getting treatment. Physicians held that surgical separation was the only way to save one child, at the cost of the other's life. When the parents refused to give consent for the procedure, the doctors went to court.

When the judge ruled in favour of separation, the parents, and the official solicitor representing child who would die, appealed. The appeals court upheld the ruling.

The author argues that the imagery and logic presented in the appeals judges' opinions indicate their bias towards doctors' right to decide, and their lack of empathy for the parents and their religious beliefs. In fact, the case is really about the rights of doctors over parents, not about whether medical intervention was needed by law.

The author's own view is that the physicians should not have sought court intervention, but tried to obtain the parents' consent before separating the twins. "I would have liked to have had the parents agree to the separation, but I do not believe the case for separation is so strong that it demands that the authority to make the decision about the medical care of their children be taken away from the parents."

(Interestingly, a similar situation in India had very different consequences. The press reported that doctors called for surgical separation, though there was no assurance that even one child would survive the procedure. The parents refused to let their children be surgically separated, on the grounds that they were a gift from God. Indeed, thousands made religious pilgrimages to see the children. In a country where the poor have to fight for access to basic care, there was no question of a hospital insisting on surgical intervention.)

Annas George J: Conjoined twins — the limits of law at the limits of life *The New England Journal of Medicine* 2001; 344 (14).