FROM OTHER JOURNALS

We scan the *Annals of Internal Medicine* (www.annals.org), *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) for articles of interest to the medical ethics community. For this issue of the *IJME* we reviewed the February–April 2004 issues of these journals. Articles of interest from the *National Medical Journal of India*, *Monash Bioethics Review* and *Developing World Bioethics* are abstracted as and when they become available.

Apologies

Learning to say sorry is hard for physicians anywhere, perhaps more so in the Indian culture where a physician has a God-like status. However, as the following articles point out, it is the right thing to do for several reasons.

Apologies have a potential for healing that is matched only by the difficulty most people have in offering them. Physicians face special challenges in this realm. They may feel shame, guilt and grief when their actions harm others, even if the fault is unclear. Ineffective communication is the single largest factor resulting in patient litigation. Good communication can avert or help end conflict, especially litigation.

Frenkel DN *et al.* Words that heal. *Ann Intern Med 2004*;140:482–483.

Mazor KM *et al.* Health plan members' views about disclosure of medical errors. *Ann Intern Med* 2004;**140:**409–18

How to get your message straight

The Indian media has been as guilty as others of writing stories that are incomplete and sensational, and rarely is there any follow up. Yet the popular media is the best way to disseminate medical information. Both media and medical staff can learn a lot from the article that follows.

Press coverage of health care is often sloppy and sensationalised. Doctors and researchers have good reasons to help journalists do their job well because the press could be a positive influence on the nation's thinking about health. Medical journalists translate complex messages, under deadline, into news that people can understand. Not surprisingly, the quality of media reports varies greatly. Doctors too bear responsibility for trying to get attention for their message rather than on getting their message right. The authors suggest improved ways for both reporters and medical staff to communicate.

Schwartz LM *et al.* The media matter: a call for straightforward medical reporting. *Ann Intern Med* 2004;**140:** 226–228.

Media hype?

Do journalisrs' report distort research findings? These two papers examine this question.

Even though a reporter's words reach the public rather than scientists or clinicians, Bubela's study found that media reports are reasonably accurate in most instances. Cases of inaccuracy may be as much a product of the researcher's overenthusiasm as of error by the reporter. Press coverage may not exaggerate wildly or contain blatantly inaccurate statements, but may be in favour or against a subject. Scientists and journalists have conflicting responsibilities because while reporters need to gain newspaper space by dramatic statements, scientists prefer cautious, detailed, and balanced reporting. Condit suggests ways for medical staff to avoid errors.

Bubela TM *et al.* Do the print media 'hype' genetic research? A comparison of newspaper stories and peer-reviewed research papers. *CMAJ* 2004;**170:**399–407.

Condit C. Science reporting to the public: Does the message get twisted? *CMAJ* 2004;**170:**1415.

Doctors and research participants

The attitudes of physicians in India are probably similar to that found in the following study done in Taiwan.

This survey of physicians from academic and community medical centres studied their attitudes and awareness of human research participant protection (HRPP). Ninety per cent of the respondents had never heard of Institutional Review Boards, the Nuremberg Code, the Declaration of Helsinki, etc. Despite this, more than 78% of the respondents felt HRPP was important and over 59% wanted research participants to be well informed and give informed consent. Physicians reported that careful selection of patients was more important than fully informing research participants, obtaining informed consent or submitting a proposal for IRB review. This study suggests that the current system for HRPP in Taiwan may not adequately protect the safety and rights of human research subjects.

Shih T. Are you suprised? A national survey of physicians' attitudes toward protecting human research participants in Taiwan. *Eubios Journal of Asian and International Bioethics* 2004;**14:**42–8.

Research on domestic violence

Domestic violence affects all strata of Indian society. Research on this subject is to be encouraged so that we may understand the roots and eradicate it. This article reminds us of researchers' special obligations to the survivors.

No matter what the form of research is, whether retrospective or involving face-to-face interviews with actual victims, there are certain basic ethical principles that investigators should follow. Safety, confidentiality and interviewer skills and training of research staff—in medical as well as social and legal assistance—are more important than in many other forms of research. The main ethical concerns related to researching violence against women are the potential to inadvertently cause distress, possibility of risk to respondents and preventing respondents from feeling that she is just a 'means' to an end, which is the study itself.

Elcioglu O. Ethics in domestic violence research. *Eubios Journal of Asian and International Bioethics* 2004;**14:**50–52.

Screening for communicable disease

The author says that the media and other groups are erroneously linking communicable disease control to immigration control and advocating stringent health measures that are unlikely to reduce tuberculosis or HIV infection in the UK and are also unethical.

Coker R. Compulsory screening of immigrants for tuberculosis and HIV is not based on adequate evidence, and has practical and ethical problems. *BMJ* 2004;**328:**298–300.

Regulating private health care

The ills plaguing the Indian medical scene are also seen in countries such as Canada and the USA. The difference is that in the West stringent laws are enforced with stiff penalties for those that break them.

Independent health facilities (IHFs) are privately owned, for-profit entities that provide therapeutic and diagnostic services such as physiotherapy and laboratory testing. These operate both within and outside the public system. These facilities depend on physician referrals for patients and offer compensation (a kickback) consisting of cash payments for each referral, discounted office space or leases for medical equipment, or business loans at below-market rates. Kickbacks and self-referrals to IHFs owned by physicians can potentially distort clinical judgement. Professional regulatory bodies such as the provincial colleges of physicians and surgeons may have the greatest expertise in governing such conflicts of interest. Authors review existing laws in the various Canadian states and suggest ways to tighten them.

Choudhry S *et al.*Unregulated private markets for health care in Canada? Rules of professional misconduct, physician kickbacks and physician self-referral. *CMAJ* 2004;**170:**1115.

Publicising study results

The disclosure of study findings to participants in research reflects the moral obligation of researchers. This is founded in the ethical principle of respect for human dignity, i.e. to avoid treating human participants as a means to an end. It has many potential benefits for participants and may have a direct impact on their quality of life. Disclosure of results may also benefit research as a whole by demonstrating its tangible benefits to the public and by engaging public enthusiasm and support for the principle of research. The authors examine ways in which disclosure of results can benefit or harm the recipient and propose ways in which researchers can accomplish this difficult task.

Fernandez CV *et al.* Considerations and costs of disclosing study findings to research participants. *CMAJ* 2004;**170 :**1417

Evidence, not intuition

Evidence- based medicine has aroused a lot of controversy in the medical field. This issue of the Journal of Medical Ethics has several articles that discuss the pros and cons of this approach in the various branches of medicine.

Evidence-based medicine (EBM), a term introduced in 1992, says that all medical action should rely on solid quantitative evidence based on the best of clinical epidemiological research and one should be cautious about actions that are only based on experience or extrapolation from basic science. The idea was proposed in 1830 by physicians belonging to 'Médecine d'Observation' in France who were reacting against a kind of medicine that would be considered 'nonsense' by today's scientific standards. It is not that EBM is the only scientific medicine and that all medicine practised before it was unscientific. EBM states that intuition and unsystematic clinical experience as well as a pathophysiological rationale are insufficient grounds for clinical decision-making. EBM challenges the paternalistic and authoritarian nature of much medical practice and helps increase awareness that, even when based on scientific methods, there is a selective and structural imbalance in the nature of the evidence that is available, because that evidence is skewed and biased toward therapeutic versus preventive interventions and toward simple pharmacological versus complex behavioural/ social care.

Liberati A *et al*. Symposium on evidence based medicine. Introduction to the symposium: what evidence based medicine is and what it is not. *J Med Ethics* 2004;**30:**120–121.

Clinicians and religion

The following article addresses a topic that is rarely dealt with in health care. How does one deal with religion in the care of patients?

Giving touching examples of patients with incurable illnesses in his oncological practice, the author asks, 'How should doctors examine and engage religion in the lives of their patients and in their own lives as clinicians? Is there any place for God at the bedside during rounds?' Religious beliefs are not always positive or beneficial. In the modern era, religion and science are understood to be

sharply divided, the two occupy different domains. Religion explores the nature of God and offers rituals for implementing God's will, whereas science eschews any such metaphysics and through experimentation unveils the workings of the material world. The author suggests that irrespective of one's religious beliefs, a physician should be aware of the spiritual beliefs of the patient so that these are taken into account when planning health care of the patient.

Groopman J. God at the bedside. *New Engl J Medicine* 2004; **350:**1176–8.

Affordability of medicines

In October 2002, the Thai Central Intellectual Property and International Trade Court ruled that because pharmaceutical patents can lead to high prices and limit access to medicines, patients are injured by them and can challenge their legality. Bristol-Meyers Squibb appealed this ruling but withdrew it in January 2004. This ruling has great international implications for health and human rights confirming that patients—whose health and lives can depend on being able to afford a medicine—can be considered as damaged parties and therefore have legal standing to sue. The Thai court case was the outcome of a learning process and years of networking between different civil society actors who joined forces to protect and promote the right of access to treatment. This ruling has set an important precedent that essential drugs are not just another consumer product but a human right and that patients are injured by patents

Ford N *et al*. The role of civil society in protecting public health over commercial interests: lessons from Thailand. *Lancet* 2004; **363:** 560–3.

Doctors and the drug industry

This collection of articles discusses the industry's influence on health professionals. The first author argues that despite evidence to the contrary, doctors do not believe that they are influenced by the pharmaceutical industry. He suggests steps that doctors can take to minimise this influence. The second author discusses the responsibility of educators to protect students from the influence of drug companies. Finally, a medical student reports on the debate and activities within the National Council of the Australian Medical Students' Association.

Breen KJ. The medical profession and the pharmaceutical industry: when will we open our eyes? *Med J Aust* 2004;**180:**409–410.

Rogers WA *et al*. The ethics of pharmaceutical industry relationships with medical students. *Med J Aust* 2004;**180:**411–414.

Hutchinson MS. Pharmaceutical companies and medical students: a student's view. *Med J Aust* 2004;**180:**414.

Voices of developing countries

For many health professionals in this part of the world, medical ethics is mostly about problems related to poverty and inequity. This special issue of the journal Developing World Bioethics carries a collection of papers on the subject.

The papers cover a range of subjects: infectious diseases which mostly affect the poor and raise special ethical issues; the need to include 'power relations' in bioethics and make it more relevant to 'real people's concerns'; distribution of research resources; patents and access to drugs, and policy options to reduce inequalities in health. The book review examines'ethics, economics, and AIDS in Africa.'

Developing World Bioethics (Special issue): distribution of resources. 2004; **4:**1–105.

Whistle blowing

When should a health professional speak to the public about perceived shortfalls in services?

This editorial discusses the case of a New Zealand orthopaedic surgeon who told the press of a fall in hospital beds for acute care. He was censured for failing to go through the correct channels. A further question raised here is the doctor's right and duty—beyond caring for patients, to speaking out on their behalf. The medical profession's voice can 'represent an important check in the system where management is making decisions which may affect people's fundamental well-being and lives'.

From the editor's desk. *New Zealand Bioethics Journal*. **4:**2–3.

Ethics in emergency medicine

Indian doctors hesitate to provide emergency care fearing that they will later be burdened with medicolegal red tape.

This article summarises some legal decisions related to emergency medical care. For example, doctors must provide immediate life-saving treatment to injured victims brought to them. The state is bound to provide adequate medical facilities. In an emergency, doctors may provide appropriate treatment—with discretion on choice of treatment—even without the patient's consent. In an emergency, doctors have the right to treat some patients on priority as they see fit. In an emergency, the doctor's priority is to save life rather than meet legal obligations.

Mathiharan K. Emergency medicare: its ethical and legal aspects. *Natl Med J India* 2004;**17:**31–5.