

## FROM OTHER JOURNALS

We scan the Annals of Internal Medicine ([www.annal.org](http://www.annal.org)), New England Journal of Medicine ([www.nejm.org](http://www.nejm.org)), Journal of the American Medical Association ([www.jama.ama-assn.org](http://www.jama.ama-assn.org)), Lancet ([www.thelancet.com](http://www.thelancet.com)), British Medical Journal ([www.bmj.com](http://www.bmj.com)), Journal of Medical Ethics (<http://jme.bmjournals.com>), Canadian Medical Association Journal ([www.cma.ca/cmaj.com](http://www.cma.ca/cmaj.com)), and Eubios Journal of Asian and International Bioethics ([www.biol/tsukuba.ac](http://www.biol/tsukuba.ac)) for articles of interest to the medical ethics community. For this issue of the IJME we reviewed the May 2005 - July 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.

### **End-of-life issues**

Withholding parenteral nutrition in a patient's final hours or days is a daily occurrence but withdrawing ventilation generates more concern; it requires an unavoidably open decision and is likely to be associated with a short interval from withdrawal to death. The author discusses how the staff of a hospice struggled with this situation. In the end the staff accepted that health-care decision-making should not be influenced by how difficult, expensive, or emotive the interventions may be, for anyone other than the patient. The decision on continuing or withdrawing potentially life-prolonging treatment is primarily the patient's dilemma, not the healthcare professional's choice.

**Gannon C. A request for hospice admission from hospital to withdraw ventilation. *J Med Ethics* 2005; 31: 383-4**

The authors describe procedures and criteria used in the Netherlands for euthanasia of newborns with severe disabilities.

**Verhagen E, Sauer PJ. The Groningen Protocol--euthanasia in severely ill newborns. *NEJM* 2005; 352: 959-62.**

Netherlands has a committee to check whether doctors have adhered to legal requirements in voluntary euthanasia. Even though Alzheimer's disease is not a terminal condition, a patient's request was considered appropriate on the basis of "suffering hopelessly and unbearably". This is a criterion for euthanasia in Netherlands.

**Sheldon, T. Dutch approve euthanasia for a patient with Alzheimer's disease. *BMJ* 2005; 330: 1041.**

### **Hospital ethics committees**

The writer argues that in European countries in transition, like Croatia, hospitals have a bureaucratic approach. Hospitals' ethics committees have a legalistic view and function mainly to analyse research protocols. Committee members are paternalistic and have an insufficient knowledge of ethical issues. It is pointed out that health-care systems are also about people and relationships. Ignoring this creates tensions as well as ethical problems.

In the first of two accompanying commentaries, Marusic responds that ethical regulations are taken lightly in transition countries. For this reason, violators them suffer relatively minor punishments.

In the second commentary, Ashcroft accepts Borovecki's analysis. Many European countries with health systems in transition are strained by problems of inadequate resources, high direct costs for patients, inequalities in access, corruption, and formal

or informal rationing. "Traditional" clinical ethics issues concern decision-making at the end of life. Resolution of conflicts between family members and staff are of less consequence. Hospitals find it more useful to set up ethics committees to satisfy foreign research sponsors' requirements, rather than to address problems of concern to patients. To be genuinely useful to clinicians and patients, and to be morally legitimate, ethics committees need to have both a clear sense of purpose and an idea of how best to achieve that purpose. Medical ethics scholars must take up the challenge of addressing the moral problems of social transition.

**Borovecki A, Oreskovic S, ten Have H. Ethics and the structures of health care in the European countries in transition: hospital ethics committees in Croatia. *BMJ* 2005; 331: 227-9.**

**Marusic A. Ethics in health care and research in European transition countries: reality and future prospects. *BMJ* 2005; 331: 230.**

**Ashcroft RE. Ethics committees and countries in transition: a figleaf for structural violence? *BMJ* 2005; 331: 229 - 30.**

### **Covert medication – is it acceptable?**

The practice of covertly administering medication is considered by some to be overly paternalistic. Others suggest that it may be acceptable if patients have permanent mental incapacity. Issues become more complex when the mental incapacity is temporary and when the medication actually serves to restore autonomy. The authors report on the case of a young man with schizophrenia, whose mother had been giving him antipsychotic medication covertly in his soup. They discuss the conflict between autonomy and beneficence/non-maleficence; the role of anti-psychotics as autonomy restoring agents; truth telling and the balance between individual versus family autonomy.

**Wong JG, Poon Y, Hui EC. "I can put the medicine in his soup, Doctor!" *J Med Ethics* 2005; 31: 262-5.**

### **How to deal with research fraud**

The author describes the case of RK Chandra, University of Newfoundland, Canada, whose published paper in *Nutrition* (2001) was proved to be fraudulent. The author says that an accusation of research fraud is a serious event and should lead to a disciplinary process conducted by a body that has the legal legitimacy to do so. Research fraud is not an isolated event. Usually the offending researcher has a pattern of similar behaviour in the past. Unfortunately, tracking down such frauds is time-consuming and expensive and therefore few wish to take the trouble.

**Smith R. Investigating the previous studies of a fraudulent author. *BMJ* 2005; 331: 288-91.**

## Should universities share or hide knowledge?

The author describes University as the "knowledge commons" in which the body of knowledge is improved by easy access to, and use by, all. In contrast is the concept of the commons where overuse by some leads to the "tragedy of the commons" where there are strong incentives for individuals to maximize their use of public resources at the expense of others. When the knowledge commons is underused due to constraints imposed by intellectual property rights and patents, it becomes a "tragedy of anti-commons". As a result, new knowledge becomes more difficult to develop, seriously undermining not just teaching and research but also knowledge transfer and economic growth. Commercial interests in education are not always detrimental and the role of universities in fostering social development and economic prosperity is welcome. To return then to the question posed in the title of this editorial, "knowledge commons or economic engine? - what's a university for?", the simple answer is "both". However, universities have a difficult task to achieve a balance between commercial influence and pursuit of knowledge.

**Williams-Jones B. Knowledge commons or economic engine -- what's a university for? *J Med Ethics* 2005; 31: 249-50.**

## How important is patient choice?

This editorial comments on the case of two patients with Parkinson's disease who sued a pharmaceutical company for discontinuing their experimental treatment; the trial of the treatment was stopped because of safety concerns. The patients claimed that as they had not experienced any adverse effects, they should be allowed to continue the treatment. Among the important issues highlighted in this commentary is that of patient choice. The writer concludes that the drug company reacted responsibly by stopping the trial when safety risks were identified. There is no mechanism to consider patient choice when making decisions about experimental treatments.

**[Editorial] Patient choice in clinical trials. *Lancet* 2005; 365:1984**

## Helping patients decide

Patients with serious illnesses such as breast cancer are understandably anxious to get the best possible care. Ideally, they should be able to access up-to-date and independent information to make the optimal choice of treatment. But this is not always possible. One example is of the UK nurse who was planning to sell her house to get an experimental treatment, falsely believing that it offered her a chance for longer survival. This shows that patients can misinterpret trial data. Doctors have to help patients make informed choices.

**[Editorial] Helping the informed patient decide. *Lancet* 2005; 365:1984**

## Listen, don't complain

Patients, as health consumers, are being asked to complain more and are encouraged to distrust doctors and complain frequently. But complaints alone will not improve the system. A well-functioning health-care system should consider the needs of those getting care as well as those delivering it. Patients with access to the Internet still need doctors' help to sift useful from

useless or harmful advice. Rather than complain, doctors and patients need to listen to one another more often.

**[Editorial] Will consumerism lead to better health? *Lancet* 2005; 366:343**

## Bioethicists for sale?

North American bioethics has a credibility problem as a result of the growing influence of the pharmaceutical and biotechnology industries on the profession. Industry has an interest in influencing bioethicists as they serve many important functions such as regulating research and setting policy through government task forces. The author notes that industry-funded bioethicists are writing articles favorable to the industry in scholarly journals. Medical journals have disclosure policies, which raise a red flag about such conflicts of interest, but the real problem is influence peddling. Newspapers can guard against such influence by following the policy: "We pay our own way. We accept no gifts from news sources. We accept no free trips. We neither seek nor accept preferential treatment that might be rendered because of the positions we hold." The editors of medical and bioethics journals should adopt a similar policy. Editors might even decide to reserve a special, clearly marked place in the journal for industry viewpoints. Then bioethicists would be faced with a choice: either forego industry funding, or forego writing scholarly articles justifying the practices of their funders.

**Elliott C. Should journals publish industry-funded bioethics articles? *Lancet* 2005; 366:422-4.**

## Talking to the relatives

A medical student describes his dilemma over the principle of confidentiality and autonomy when a competent patient's relatives request information. He observes that while this breaches confidentiality, involving relatives tended to promote the exchange of information and the evaluation of choices - which actually promoted patient autonomy. The benefit of talking to relatives was greater than the rare, but significant, distress caused by sharing information when a patient wanted to maintain privacy. The writer argues that classroom ethical teaching is limited when based on theory alone. It needs to be grounded in clinical situations.

**Mytton O. Should doctors talk to relatives without a competent patient's consent? *J Med Ethics* 2005; 31: 266**

## Doctors and torture

The author criticises the US government for allowing the torture of prisoners in Iraq and Guantanamo Bay, Cuba. He cites legal precedents endorsed by the US in the pre-9/11 era that forbade the use of such tactics even in war. He states that medicine, law, and the military have particular obligations to prevent torture; physicians have the obligations of the universally recognised and respected role of healers; lawyers have the obligations to respect and uphold the law, including international humanitarian law; and military officers have the obligation to follow the international laws of war, including the Geneva Conventions which forbid the use of torture.

**Annas GJ. Unspeakably Cruel -- torture, medical ethics, and the law. *N Engl J Med.* 2005; 352:2127-32.**

### **Migration of health workers**

In the past, the migration of doctors and nurses to richer countries was a passive process determined by the individual migrant. In recent years, however, the demand for health workers in many countries in the West has led to active their recruitment from developing countries. The right of the individual health worker to emigrate has to be balanced against the negative consequences of such migration on the health infrastructure of countries, especially in Africa. The author explores policy options to minimise the consequences of this migration of health workers.

**Ahmad OB. Managing medical migration from poor countries. *BMJ* 2005; 331: 43-5.**

### **Guidelines for practice**

This paper provides clinical and research ethics guidelines to physicians in clinical practice.

**Snyder L, Leffler C; Ethics and Human Rights Committee, American College of Physicians. Ethics Manual: fifth Edition. *Ann Intern Med* 2005; 142: 560-82.**

### **Gift authorship for senior academicians**

One's reputation and standing in academia depends on the number of articles one publishes. Senior researchers seem to go to considerable lengths to increase the list of publications in their *curriculum vitae* at the expense of junior researchers. By this behaviour they indicate to their juniors that academic publication is not about maximising the quality of medical research but simply a criterion for career progression. To prevent such abuse, academia must create mechanisms to prevent gift authorship among senior academics.

**Wagena EJ. The scandal of unfair behaviour of senior faculty. *J Med Ethics* 2005; 31: 308.**

### **Dilemmas in care of the elderly**

The authors discuss the ethical problems in caring for the elderly. They describe situations where physicians must exercise not just medical but also moral and social judgments to come up with the best possible treatment for their patients. They note that even when a person's cognitive capacity is impaired there are tools that can be used to determine competency. Patient autonomy should be taken into account when planning any caretaker situation for the patient.

**Rosin AJ, van Dijk Y. Subtle ethical dilemmas in geriatric management and clinical research. *J Med Ethics* 2005; 31: 355-9.**

### **Consequences of new technologies**

Innovative medical technologies can raise new ethical, legal and social dilemmas. This is particularly so in area of antenatal screening, which is dominated by the language of risk and probabilities. Further, first trimester screening with biochemical and ultrasound markers is being proposed as advance on second trimester serum screening for Down's syndrome and neural tube defects, yielding higher detection rates of Down's syndrome at an earlier gestational age.

This article explores the experiences of 14 women offered 'innovative' first trimester screening within the context of a detailed ultrasound scan. The study is set within the UK, where recent policy changes mean that screening for fetal anomalies, particularly Down's syndrome, will become a routine part of antenatal care. This paper focuses on the significance of the scan in first trimester screening, and some potential dilemmas for women. It then discusses how women made their decisions about screening, in particular, their work as 'moral pioneers'.

**Williams Clare, Sandall Jane, Lewando-Hundt Gillian et al Women as moral pioneers? Experiences of first trimester antenatal screening *Social Science & Medicine* 2005; 61: 1983-1992.**