

## FROM OTHER JOURNALS

We scan the *Annals of Internal Medicine* ([www.annals.org](http://www.annals.org)), *New England Journal of Medicine* ([www.nejm.org](http://www.nejm.org)), *The 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.unescobkk.org/index.php?id=2434](http://www.unescobkk.org/index.php?id=2434)) for articles of interest to the medical ethics community. For this issue of the *IJME* we reviewed the November 2006 - January 2007 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.

### **The ethics of stunting growth**

The parents of a mentally challenged girl requested and obtained permission from the ethics committee of the hospital before they asked for treatment that would stunt their daughter's physical growth in order to enable them to continue caring for her. The ethics department assented saying that the benefits to the girl outweighed the risks. The parents made this situation public to generate a debate about this and similar situations.

**Editorial. Ashley's treatment: unethical or compassionate? *The Lancet* 2007; 369: 80**

### **Strategies for support**

The American College of Critical Care Medicine published guidelines in the February 2007 issue of *Critical Care Medicine* for support of patients and families in the adult, paediatric and neonatal intensive care units. The focus is the patient rather than the clinician or the disease. To summarise, the patient and family must be kept informed and involved in medical decision making; physical and emotional support should be provided to patient and family; patient care must be integrated across health care providers; medical staff should understand the patient's cultural beliefs as they apply to the illness; medical staff should understand and apply prevention strategies to diverse populations.

**Barclay L. New guidelines issued for family support in patient-centred ICU. <http://www.medscape.com/viewarticle/551738>**

### **The effects of profit on health care**

In Canada, the government pays for long-term care, which can be delivered currently in non-profit or for-profit institutions. Unlike the US, Canada does not have minimum requirements for long term care facilities, leaving these entities free to make spending decisions. The authors found that patients had better outcomes when they were in non-profit institutions with certain characteristics. Their findings have implications for Canadian public policy.

**McGrail KM, McGregor MJ, Cohen M, Tate RB, Ronald LA. For-profit versus not-for-profit delivery of long-term care. *CMAJ* 2007; 176:57-8.**

### **Legalising self-testing for HIV**

Since 1992 self-testing for HIV has been illegal in the UK. The author argues that anti-retroviral drugs have transformed HIV from a fatal to a chronic disease. Many people with HIV are unaware of their condition, others fear stigma that may result from testing in a medical setting. Promoting patient autonomy

requires that patients have the freedom to be tested when, where and how they desire. Legalising self-testing would increase detection and early treatment of HIV positive persons, curbing the spread of the disease. The author discusses the pros and cons of such self-testing.

**Frith L. HIV self-testing: a time to revise current policy. *The Lancet* 2007; 369:243-5**

### **Deciding to die**

Patients' views should be taken into account in the debate on voluntary euthanasia and assisted suicide. The authors asked people who were terminally ill about their views. Those who had seen others die were strongly of the opinion that people should have this right.

**Chapple A, Ziebland S, McPherson A, Herxheimer A. What people close to death say about euthanasia and assisted suicide: a qualitative study. *J Med Ethics* 2006; 32: 706-10.**

### **Trust is two-way traffic**

Trust is a key element of a good patient-physician relationship. Usually the factors that promote or hinder a patient's trust in the physician or medical system are discussed but the reverse, trust that the physician develops in the patient, is rarely addressed though it is just as important. The author discusses this aspect in the context of prescribing narcotics.

**J Miller. The other side of trust in health care: prescribing drugs with the potential for abuse. *Bioethics* 2007; 21: 51-60.**

### **Ethics and economics**

The author discusses how economic pressures impinge on end-of-life ethics. He says that society has been largely silent on this aspect and that we must face the issues in order to understand how end-of-life decisions are determined by the economic climate affecting health care at that moment.

**Epstein M. Legitimising the shameful: end-of-life ethics and the political economy of death. *Bioethics* 2007; 21: 23-31.**

### **The consequences of deception**

Caretakers at times lie to demented patients or deceive them to reduce their agitation or to console them. The author discusses the ethical considerations that should determine these actions and reminds us that "not only the patient but also the nursing and medical staff are affected by the use of lies and deception. The effects of lying and deceiving on their integrity and trustworthiness should also be taken into account."

**Schermer M. Nothing but the truth? On truth and deception in dementia care. *Bioethics* 2007; 21:13-22.**

## The demands of dementia

Through the description of a specific case of a demented mother and her caregiver daughter, the author analyses how responsibilities change in progressive dementia and the stress this places on the family.

**Goldstein M, Abma T, Oeseburg B, Verkerk M, Verhey F, Widdershoven G. What is it to be a daughter? Identities under pressure in dementia care. *Bioethics* 2007; 21: 1–12.**

## The revolving Gates of aid

Notwithstanding the enormous good done by the vision and generosity of the Gates, the Gates Foundation invests its money in companies whose practices hurt the very people that the foundation is trying to help. The Foundation has responded saying they avoid glaring conflicts such as investing in tobacco stocks and in companies in which the Gates family has an interest, but researching for less harmful companies would distract the foundation from its primary purpose of helping the poor. On the contrary, say others, the investment money is much larger than the grants and should be leveraged towards environmental, social and political good. And this applies to all investors, irrespective of the size of the assets invested.

**Editorial. Governance questions at the Gates Foundation. *The Lancet* 2007; 369:163.**

## Smokers on the operating table

Glantz believes that doctors should not allow the current anti-smoking zeal in the western world to intrude on the doctor-patient relationship. He argues that while doctors should advise patients to stop smoking, a refusal to stop should not lead to denial of needed surgery. The argument that smokers will cost the hospital more due to complications, is selectively used as many other non-smoking patients cost more due to other lifestyle factors such as obesity, contact sports, etc.. Peters strongly advocates discriminating against smokers to conserve scarce funds, to reduce preventable postoperative complications that occur with greater frequency in smokers. He advocates applying this only to elective surgeries.

**Should smokers be refused surgery? Glantz L (against). *BMJ* 2007; 334:21. Peters MJ (for) *BMJ* 2007; 334:20.**

## Religion and health care

Esmail argues against tailoring services specifically for Muslims. Every one has multiple identities and by emphasising the religious identity, the minority community is branded the "other," encouraging discrimination and persecution. He acknowledges that faith matters to some, so providing appropriate religious services and particular foods when requested is appropriate. But to lump all Muslims as automatically having these preferences is incorrect. It is better to accept a pluralism that respects different needs of different peoples than force every one into one homogenous category based on their religion. Sheikh favours special services saying that Muslims have the poorest health profile in the UK and improving this may be better accomplished by providing faith centred health services. Making male infant circumcision available through the NHS, flagging those drugs that may have pork or alcohol ingredients, providing for ablution and prayer

areas in clinics and hospitals, highlighting special risks and immunisations for Haj pilgrims, providing a physician of the same gender, are some of the facilities that would facilitate increase in use of health services by Muslims.

**Should Muslims have faith based health services? Esmail A (against). *BMJ* 2007; 334:75 Sheikh A (for). *BMJ* 2007; 334:74.**

## The ethics of prenatal testing

Huntington Disease, an autosomal dominant disorder without effective treatment, manifests in middle life as involuntary movements and dementia progressing to death over 10 to 15 years. Should a couple that has a risk for having a child with this disease, be offered the diagnostic prenatal test even if they decline abortion if the test is positive?

**Duncan RE, Foddy B, Delatycki MB. Refusing to provide a prenatal test: can it ever be ethical? *BMJ* 2006; 333:1066-8.**

## Making the HPV vaccine mandatory

Michigan state in the US has proposed making the Human Papilloma Virus (HPV) vaccine compulsory for girls entering sixth grade as the vaccine has maximum benefit before a person becomes sexually active. The vaccine is not approved as yet for use in boys. Religious groups are opposing it for undermining abstinence-based preventive messages. Others, while approving its use, do not want it mandated. Women's groups support vaccination because of serious consequences such as cervical cancer, from contracting HPV. The author discusses the various reasons in favour of and opposing the mandated programme.

**Colgrove J. The ethics and politics of compulsory HPV vaccination. *N Eng J Med* 2006; 355:2389-91.**

## The US and neglected diseases

The US has usually been cooperative on issues of global health but has rejected offers of cooperation on neglected (tropical) disease research and treatment. The editorial attributes this to "vertical, project-specific, target-driven funding in global health that has mainly benefited the 'big three' diseases (HIV/AIDS, malaria, and tuberculosis) but ignored others that can cause even greater morbidity." The neglected-disease community wants to impact several diseases, e.g. parasitic infections, simultaneously by making maximum use of available resources.

**Editorial. US AIDS coordinator shuns collaboration on neglected disease. *The Lancet* 2006; 368:1547.**

## Pitfalls of advertising medicines

The editorial advises caution, based on the US experience, before Europe considers relaxing the ban on advertising medicines to the public. The US Government Accountability Office review of such advertising from 1997 to 2005 found sufficient evidence to prove that companies use the advertising to simply push new and expensive drugs in place of older inexpensive ones.

**Editorial. The direct-to-consumer advertising genie. *The Lancet* 2007; 369:1.**

## Unconscious and on trial

In December 2006 an amendment to the existing rules in the

UK was approved to allow recruitment of unconscious patients in emergency situations in clinical trials, if the ethics committee gives prior approval for such a trial. Such patients, often trauma victims, did not get the benefit of evidence-based medicine as there were few or no trials to compare treatment outcomes. The authors hope that this situation will now improve.

**Shakur H, Roberts I, Barnetson L, Coats T. Clinical trials in emergency situations. *BMJ* 2007; 334: 165-6.**

### **Culture and clinical practice**

The authors did a survey in four European countries, Norway, Italy, Switzerland and the UK, to determine if cultural variations change the need for ethical support in clinical practice. They found that despite significant differences in lifestyles and culture in the four countries, the doctors surveyed faced similar dilemmas and appreciated similar help. Disagreement among care givers, and uncertain or impaired decision making capacity, was a common concern and professional reassurance about their decisions being correct, and help in weighing outcomes, was welcome.

**Hurst SA, Perrier A, Pegoraro R, Reiter-Theil S, Forde R, Slowther A-M et al. Ethical difficulties in clinical practice: experiences of European doctors. *J Med Ethics* 2007; 33:51-7.**

### **Neutralising risk-benefit analysis**

The author describes how a pharmaceutical company concealed data on the adverse effects of a new drug from the FDA. Usually, the company that manufactures a drug itself conducts the risk-benefit analysis of the new drug. So often companies prefer to not conduct a study at all in case the results are not favourable to the new drug. The author feels that studies of drug risks should be supported nationally to avoid such incidents.

**Avorn JN. Dangerous deception—hiding the evidence of adverse drug effects. *N Eng J Med* 2006; 355:2169-71.**

### **Conflicts of interest on the IRB**

The authors surveyed 893 IRB members at 100 academic institutions and found that even though 36 per cent had recently had such financial relationships, their colleagues on the IRB felt that this did not affect their judgement, and that their views were valuable in decision-making. The authors feel that regulations governing such participation should be tightened.

**Campbell EG, Weissman JS, Vogeli C, Clarridge BR, Abraham M, Marder JE et al. Financial relationships between Institutional Review Board members and industry. *N Eng J Med* 2006; 355:2321-9.**

### **The future of quackery**

This editorial notes that there may be some one million unqualified providers, or "quacks", in India. The idea that some medical care providers were doctors and others were quacks began after the setting up of formal training and accreditation systems. Still, there is no doubt that untrained providers can be dangerous.

However, one must understand the context in which quacks thrive. First, there is often an unfortunate symbiotic relationship between the two groups as qualified doctors get patients

referred to them by quacks. Second, quackery flourishes where people do not have access to affordable quality medical care. The writer notes that the National Rural Health Mission seeks to train quacks and permit them to perform a limited medical practice. This would certainly benefit the millions of deprived people in rural areas. But in the end, "The future of quackery depends on how deep and strong is the symbiosis of quacks and qualified practitioners. The earlier that symbiosis is broken and the earlier rational medicine can be made universally available, the earlier will quackery recede."

**Editorial. Symbiosis with quackery. *BODHI* 2006; 73 (Nov-Dec): 97-8.**

### **Liver transplant programmes**

How best should new medical technologies be developed? This question is discussed with reference to liver transplant in India. The first writer argues for caution in the development of living donor liver transplant (LDLT) programmes. "The single most important difference between the deceased- and living-donor procedures is the performance of a potentially life-threatening operation on a healthy person." It is estimated that 20 per cent of donors experience some complication, and available figures on donor mortality are believed to be underestimates. LDLT programmes should develop only in a regulated manner as a development from a long-standing and active cadaver-based programme, with ethics approval and systematic review of the results. Arguing against the explanation that living donor programmes are necessary because of the shortage of cadaver livers, the author states that "cadaveric liver transplants are not being performed not because of unavailability of cadaveric organs but because of lack of infrastructure, recipients or organ-sharing mechanisms, all potentially correctable problems." Also, liver transplant programmes in countries like India are in the private sector where they are driven by the market and quick results and profits, not by what the community needs.

The second author argues that LDLT programmes must be developed because of the large gap between supply and demand for livers, the failure of the cadaver programme in the last 12 years, and the existence of an infrastructure of trained surgeons and equipped centres. Experience in deceased-donor liver transplantation (DDLTL) adds nothing to the knowledge and expertise required to prevent donor complications. This can only be gleaned from the experience of other established LDLT centres and from one's experience with liver resections. The infrastructure required for LDLT is not linked to DDLTL. Likewise the set of skills required are different and surgeons with experience in DDLTL programmes will need training in LDLT. "It cannot be stressed strongly enough that a living-donor liver transplant is an operation with the highest of stakes and complexity, and should only be undertaken by surgeons who have received direct training at LDLT centres rather than develop as an extension of their DDLTL skills."

**Nagral S. A deceased-donor liver transplant program must precede a living-donor program. *Indian J Gastroenterol* 2006; 25:302-4. Soin AS, Vasudevan KR. A successful deceased-donor liver transplant program is not a prerequisite for a living-donor program. *Indian J Gastroenterol* 2006; 25:305-7.**