FROM OTHER JOURNALS

We scan the Annals of Internal Medicine *(www.annals.org)*, New England Journal of Medicine *(www.nejm.org),* Lancet *(www.thelancet.com),* British Medical Journal *(www.bmj.com)*, Journal of Medical Ethics *(http://jme.bmjjournals.com),* Canadian Medical Association Journal *(www.cma.ca/cmaj.com), and Eubios Journal of Asian and International Ethics (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 May 2007 - July 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.*

Do drug ads influence doctors?

The former editor of the BMJ argues that to have financial independence a journal must have multiple sources of income, such as subscriptions and reprints of articles, of which drug advertising is the most profitable. Many companies advertise; therefore none has the dominant power to influence policy. Also we are so bombarded by advertisements that we tend to ignore them. Doctors are more influenced by visits from drug representatives than by advertisements in medical journals. Reprints of articles that drug companies buy in bulk produce more revenue for the journal, and the temptation to print such industry- sponsored articles, with an eye on reprint sales, is more damaging than the influence of advertisers. Banning advertisements will also mean greater dependence on owners of journals who can, and have, interfered with editorial independence. The opposing viewpoint is that drug advertisements are biased and hype the scant benefit of the drug while playing down its side effects. If editors refuse to publish an inaccurate article in their journal, why should they publish inaccurate data as an advertisement? If an advertisement is accepted it should be vetted for the accuracy of its claims.

Smith R. Should medical journals carry drug advertising? Yes. *BMJ* 2007; 335: 74. Williams G. Should medical journals carry drug advertising? No. *BMJ* 2007; 335: 75.

Advance directives are not enough

Advance directives contain instructions about what care one wants or, more important, does not want at the end of one's life. The author argues that such a directive cannot have an answer for every crisis that may occur towards the end of life. It is better to have several conversations with one's loved ones to make one's wishes clear. Finally, one must trust the doctor to guide the family compassionately towards the correct decisions.

Perkins HS. Controlling death: the false promise of advance directives. *Ann Int Med* 2007; 147: 51-7.

Treat patients with dignity and compassion

The author describes the four essential components to treating patients with dignity that preserves their sense of identity and self worth. These are: the right attitude, behaviour that reflects this attitude, compassion that should be the dominant emotion and dialogue with the patient that expresses all of the above.

Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007; 335:184-7.

Research on prisoners

Research involving prisoners was banned in the US in 1978 following public outcry against experiments conducted in the prison population. Today it is accepted that true informed consent can never be obtained in a prison setting, particularly when financial or other incentives are offered. But, in 2004, an Institute of Medicine report recommended that research be allowed in the prison population but with strict safeguards of the subjects. Prison conditions would receive more scrutiny and prisoners would have access to trials which could benefit their medical conditions. The author accepts the arguments in the IOM report in favor of such research but advises caution.

Lerner BH. Subjects or objects? Prisoners and human experimentation. *N Eng J Med* 2007; 356:1806-7.

How doctors grieve

The author reflects on why he feels a decreasing degree of sadness with each death in his patient population. The need to protect oneself from another's suffering lest it impair one's judgment, the feeling of hopelessness in the face of overwhelming medical problems, and the possibility of medical errors, are some possible reasons which may alter a doctor's behaviour. The author states that unless doctors acknowledge and deal with these emotions, the doctor-patient relationship can get dehumanised.

Berry PA. The absence of sadness: darker reflections on the doctor-patient relationship. *J Med Ethics* 2007; 33:266-8.

Drug company funding and patient groups

The first author argues that provided the group and the donor have the same point of view there is no harm in accepting money. The funding should be open, with no strings attached and from multiple sources, so no one company can dominate. Since all donors, whether industry or government, expect some degree of control, it is best to go to the public at large for donations but this is harder when the subject, like stem cell research, is difficult to explain to the general public. Patient groups need to be pragmatic and accept funds to reach a wider audience, as long as they are prepared to walk away from dubious donors. The second author feels that accepting funds would damage the impartiality of the group and may skew the policy so that it is favourable to the sponsoring company. A disclosure of such funding is not enough to prevent biased advocacy.

Kent A. Should patient groups accept money from drug companies? Yes. *BMJ* 2007; 334:934. Mintzes B. Should patient groups accept money

from drug companies? No. *BMJ* 2007;334:935.

What insurance companies should know about you

The first author argues that since insurance companies seek and obtain other kinds of health information, like smoking and drinking habits, to determine risk, and genetic information should be treated in the same way. If society feels that all healthy people in a society should share the burden of the unhealthy, then no information needs to be given to the insurer. However if that scenario does not exist then the insurer should have access to genetic information along with other health information; if the person is denied or charged an exorbitant premium this should be challenged in court, to force the insurers to make their reasoning public. This will allow misconceptions about genetic information to get cleared. The second author worries that disclosing genetic information would lead to discrimination by insurers against those who are perceived to be at a higher risk. Genetic information could be misinterpreted by the insurer as indicating a definite risk of disease rather than just the probability of disease. Disclosure may also result in very high, unaffordable insurance premiums.

Holm S. Should genetic information be disclosed to insurers? Yes. *BMJ* 2007; 334:1196. Ashcroft R. Should genetic information be disclosed to insurers? No. *BMJ* 2007; 334:1197.

Research ethics guidelines for developing countries

The European Commission plans to use its research budget to build capacity and develop country-specific ethical guidelines for research. Of the 100, 000 clinical trials taking place around the world, 10 per cent are in developing countries. This number is expected to grow in the coming years.

Watson R. Developing countries need stronger research guidelines. *BMJ* 2007; 334: 1076.

Deception

The author argues that while truthfulness is mandatory in a doctor-patient interaction, deception is morally acceptable in certain situations. He proposes a stepwise chart to be used by a doctor to determine whether or not the deception being is ethical. The chart is also useful for teaching ethical reasoning to medical students and residents.

Sokol DK. Can deceiving patients be morally acceptable? *BMJ* 2007; 334: 984-6.

Opt-out for organ donation?

The first author feels that it is time to give up the failed opt-in system as countries with opt-out system have far higher rates of organ donation. Presumed consent does not mean that organs are removed without consulting the relatives. They are consulted at every step and organs are taken only with their consent. The second author feels that many variables affect the rate of organ donation in a country, not just the procurement of organ without explicit permission. These include the availability of trained staff and intensive care beds, and the extent of information disseminated to the population. Without such an infrastructure, the opt-out system will not result in higher rates of organ donation. Surveys show that 90 per cent of the general public support organ donation; organs for transplant fall short of the demand because relatives are unaware of the wishes of the deceased.

English V. Is presumed consent the answer to organ shortages? Yes. *BMJ* 2007;334:1088. Wright L. Is presumed consent the answer to organ shortages? No. *BMJ* 2007; 334:1089.

Disclosing a mistake

Though doctors used to be reluctant to disclose medical errors, they are becoming more receptive to the idea. They need training on how to communicate these unpleasant details to patients. The legal climate too must change to assure that transparency does not result in lawsuits. The authors predict more transparency in the future in this area of medicine.

Gallagher TH. Studdert T, Levinson W. Disclosing harmful medical errors to patients. *N Engl J Med* 356:2713-9.

The need to compensate vaccine-related injury

Vaccination protects not just the person getting it but society at large. Vaccination-related injury should be compensate as the person is contributing to the public good. The USA introduced a no-fault compensation law to ensure that people would not sue vaccine manufacturers and cripple the production of vaccine and there would be no public outcry against getting vaccinated. The author urges the enactment of a similar law in Canada.

Wilson K. Protecting vaccine programs and the public. *CMAJ* 2007; 176: 1681.

Whose genes are these?

In this debate on who owns an individual's genetic information - the individual or the entire family -- the first author argues that the right to privacy of information must be balanced against the harm that would result to another family or individual if the information is not shared, as in a hereditary genetic disorder. The second author feels that genetic information is private and should remain so. He says that this information is different from that in an infectious epidemic where information about a person's illness is vital to protect others from harm.

Lucassen A. Should families own genetic information? Yes. *BMJ* 2007;335:22. Clarke A. Should families own genetic information? No. *BMJ* 2007;335:23.

Surgeons must look for signs of child abuse

This editorial discusses the need for paediatricians and paediatric surgeons to be on the watch for signs of child abuse in their patients, and respond appropriately. There are few data from India on child abuse and the reported incidence may only be the tip of the iceberg.

Doctors should be aware of bruising, bite marks, burns, bone fractures or trauma to the head or abdomen. Certain fractures are uncommon in the paediatric population; traumatic sternal segment dislocation is considered to be the result of child abuse until proven otherwise. It is the moral duty of the attending doctor to document and report the matter to the appropriate agencies to protect the child. There may be lethal consequences if child abuse is not prevented or managed in time.

Gupta DK. Child abuse: an ongoing stigma for civilized society. *J Indian Assoc Pediatr Surg* 2007;12:63-64

Indian law discourages care to people attempting suicide

This article on suicide prevention in India notes that according to Section 309 of the Indian Penal Code, "whoever attempts to commit suicide and does any act towards the commission of such an offense shall be punished with simple imprisonment for a term which may extend to one year or with a fine or with both".

As a result, emergency care to those who have attempted suicide is denied as many hospitals and practitioners hesitate to provide the needed treatment fearful of legal hassles. Data on attempted suicides become difficult to ascertain as many attempts are described to be accidental to avoid entanglement with police and courts.

Vijaykumar L. Suicide and its prevention: The urgent need in India. *Indian J Psychiatry* 2007;49:81-84

Ethical concerns in HIV/AIDS research in India

The authors discuss major ethical concerns in HIV/AIDS research in India.

A study amongst pregnant women in Maharashtra found that, after group education and counseling, only 38% women had understood six of eight key issues of informed consent about HIV/AIDS.

Research organizations must publish their findings. NACO should publish the results of its use of nevirapine prophylaxis so that the benefits and limitations of the interventions can be gauged by the scientific community.

Administration of a single-dose of nevirapine could result in the development of resistant HIV strains and limit future treatment options for the mothers. New regimens are also safe in pregnant women. However, WHO continues to include single dose nevirapine as one of the alternative regimens.

Corporate or political groups may attempt to influence and control the study design. Researchers might subordinate subjects' welfare to the objectives of the study.

In short, the populations most vulnerable to HIV infection and AIDS are the poor, uneducated and powerless – who are also most vulnerable to exploitation in research.

Salvi V, Damania K. HIV, research, ethics and women. *J Postgrad Med* 2006;52:161-2.

Health professionals' responsibility to document human rights violations

With examples from the US government's response in the early days of the HIV/AIDS epidemic, the genocide in Rwanda, and the role of health professionals witnessing human rights abuses in Nepal, the authors discuss the movement away from neutrality towards an activist approach. They also discuss the responsibility of medical practitioners to document and bear witness to violations of human rights, and to intervene to alleviate suffering if possible. This paper is one of a series on health and human rights.

James Orbinski, Chris Bevrer, Sonal Singh. Series, Health and Human Rights Violations of human rights: health practitioners as witnesses *Lancet* 2007; 370:698-704

Stigma and discrimination against HIV

This cross-sectional survey looked at stigma and discrimination by health care providers with relation to people with HIV in India. Of the 2,200 providers interviewed, less than 25 per cent knew that HIV screening was not recommended before surgery. Almost 20 per cent had refused treatment to people living with HIV or AIDS at least some of the time. Nearly half of them identified and labelled them; Almost 24 per cent of them isolated them, almost 14 per cent postponed or changed treatment on the basis of the patient's HIV status. Sixty-seven per cent screened for HIV before elective surgery. While almost 65 per cent were aware of the existence of national guidelines, less than 38 per cent had read them.

Kurien M, Thomas K, Ahuja RC, Patel A, Shyla PR, Wig N, et al. Screening for HIV infection by health professionals in India. *Nat Med J India* 2007; 20: 59-66.

Doctors know little about palliative care

This pilot cross-sectional qualitative study collected information from 50 providers of palliative care, 20 cancer patients and 30 of their relatives. Few physicians could enumerate more than three important technical elements of end-of-life care. None of the physicians had received training in palliative care services. Patients and their relatives felt the explanations and counselling were inadequate. All but one of the cancer patients wanted to use special services but were unaware of them.

Gupta V, Kumar Sandeep, Shukla A, Kumar Shailendra, Kumar Surendra. End-of-life care of terminally ill geriatric cancer patients in northern India. *Natl Med J India* 2007; 20: 74-7.

Arguments for and against folate fortification

The article supporting fortification argue that it has demonstrably led to a marked reduction in the number of babies born with neural tube defects. As many pregnancies are unplanned adding folate to the diet after pregnancy is confirmed will not reduce risk. Data do not support the claim that this supplementation leads to an increased risk of colorectal cancer. There is also some evidence that folic acid reduces the risk of cleft palate and prevents cognitive decline in old age.

Those opposing fortification state that the primary justification for this practice is a reduction of neural tube defects among newborns, though it might also reduce the risk of certain cancers and protect against cardiovascular disease. But folate metabolism is complex and synthetic folate has different effects than do naturally occurring folate in foods. Recent studies have also questioned the protection against cancer and cardiovascular disease; on the contrary its use may lead to an increase in colorectal cancer. They advise against fortification until more data become available.

Wald NJ. Should folic acid fortification be mandatory? Yes. *BMJ* 2007; 334:1252. Hubner RA. Should folic acid fortification be mandatory? No. *BMJ* 2007; 334:1253.