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.BMJ journals.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 Feb 2008-April 2008 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.*

Too many women in medicine?

Dacre, a female dean at a university, says that the medical profession should seek the brightest and best candidates, irrespective of gender. Female physicians are more apt to provide emotional support to their patients and encourage greater caring and nurturing attitudes. Many patients prefer to see a doctor of the same gender; to accommodate their wishes it would be advisable to have an equal number of male and female doctors. She admits that currently there are more female than male medical students, but anticipates that the workplace will have equal numbers because female physicians are more likely to work flex hours. Pointing to fewer females in the higher ranks of academia and those medical specialities that demand greater time commitment, she makes a plea for greater flexibility during training and working hours for women in order to maximise their potential. McKinstry, a male general practitioner, argues that women continue to bear a greater burden of social responsibility as a result of societal attitudes and thus have less time for work. Therefore, they tend to work part-time throughout their lives, and not just while raising children. They retire earlier and are less productive in research, teaching and administrative activities. He says that the preponderance of females in the profession will reduce the available physician workforce at a given time and strain the profession. Therefore, he encourages reducing the number of entering female students to equalise the numbers.

Dacre J. Are there too many female medical graduates? No. *BMJ* 2008; 336:749. McKinstry B. Are there too many female medical graduates? Yes. *BMJ* 2008; 336: 748.

Is a conflict of interest declaration in the public interest?

Lee argues that the hunt for conflict on interest must go on to reassure the public that their doctors do not have any hidden agendas to promote a particular drug or therapy. The pharmaceutical industry spends more than twice the amount on marketing as compared to research and development of drugs. The marketing techniques to influence doctors through freebies and lucrative fees for promotional lectures create an unhealthy environment. Several scandals exposed by the media have eroded public trust in the ability of doctors and of the industry to police itself. Therefore, a continued scrutiny of the behaviour of doctors to identify and eliminate conflicts of interest is essential.

Strossel discusses why in his opinion the hunt has gone too far. He claims that it is carried out by activists who are anti-business and demonise even a minor infraction by industry. If monetary transactions between patients and doctors, hospitals and insurance companies do not amount to a conflict of interest, then why should any ties between a doctor and industry be subject to this labelling? He claims that there is no objective evidence that financial interest in a product by a doctor has caused harms. He says that stringent regulations exclude the best qualified doctors from speaking engagements and committees, and eventually harm research. He is of the opinion that is time for regulators to reject strict rules that impede innovation. The author has declared his conflict of interest by revealing his extensive ties to pharmaceutical industry.

Lee K. Has the hunt for conflicts of interest gone too far? No *BMJ* 2008; 336: 477. Stossel TP. Has the hunt for conflicts of interest gone too far? Yes. *BMJ* 2008;336:476 .

Revealing genetic information: patient interest or the greater good?

Illustrating the ethical question of whether physicians should warn patients' relatives of genetic risks with a case study, the author discusses the responsibility of a physician to the patient who insists on keeping the health risk private. He balances patient confidentiality against responsibility to others who are part of society and concludes that when others are likely to be seriously harmed by withholding of information, then the physician must act in the interest of the greater good.

Lacroix M. Should physicians warn patients' relatives of genetic risks? *CMAJ* February 26, 2008; 178 (5)

Analysing surgical outcomes

Variability in surgical outcomes is influenced by many factors. One is volume. Surgeons and hospitals that perform large numbers of a particular surgical procedure, irrespective of the complexity of the procedure, will have a lower morbidity and mortality for the procedure. The author recommends that this data should be collected and analysed not just nationally, but also at a local level so that they can provide immediate feedback to the concerned individuals.

Holt PJE et al. How to improve surgical outcomes. *BMJ* 2008; 336: 900-1.

Does the doctor know how to talk?

Lack of effective communication skills is one major factor leading to complaints from patients. Some doctors have inherently better interpersonal abilities than others, but this skill can be measured and taught early during the training period. This was determined in a Canadian study where physicians in training were tracked for two to 12 years. Those with poor results in communication skills in an exam at the outset of the training period were found to have a higher number of patient complaints than their cohorts during the study period. Surgery and family practice specialities had higher complaints than other fields. Assessment of interpersonal skills is far from perfect; nevertheless, doctors who fail or barely pass these assessments need greater supervision and support to enable them to master these skills. Poor communication may not be an isolated deficiency, but an indication of global deficit in knowledge, or health problems such as depression. Intervention strategies, though imperfect, must be incorporated in every training programme.

Kinnersley P et al. Complaints against doctors. *BMJ* 2008; 336:841-2.

Reflect to improve

The authors develop on the theme of teaching medical students to be self-assessing through a case study approach. A good student who has problems communicating with some patients but not others is evaluated in this article. Through a five-step process that includes general assessment, action, looking back on action, analysis and alternative actions, the student learns to be reflective and use external support to become a better physician.

Driessen E et al. The self critical doctor: helping students become more reflective. *BMJ* 2008;336: 827-30.

Sedation for end-of-life care

Continuous deep sedation is used in the Netherlands to alleviate the suffering of those patients who have a life expectancy of two weeks or less. There is concern whether its use has increased to side-step the onerous procedures in place for euthanasia. Also, there is confusion about the difference between palliative and terminal sedation. The former is used to remove discomfort for a patient temporarily while other, slower treatments begin to provide more effective resolution of symptoms. The goal of sedation in this case is not death, though that may occur. In terminal sedation death is imminent and the goal is to make it as painless as possible. In continuous deep sedation, similar to palliative sedation, the medication, usually midozolam, a benzodiazepine, is titrated to provide sedation that is intermittent and allows the patient to communicate in between. The USA and the UK have accepted the use of continuous deep sedation and other countries also may follow suit, so it is important to define the procedure and its goals rigorously.

Murray SA et al. Continuous deep sedation in patients nearing death. BMJ 2008;336:781-2.

Systems that neglect patients

The authors, registrars in a UK hospital, point out the disservice done to patients by a policy adopted by the National Health Service. The policy was crafted to reduce excessive referral to specialists, reduce hospital use and assure accurate accounting. It requires the specialist at the hospital to treat only the condition for which the patient was referred by the general practitioner. Even if another, equally bothersome condition is identified while the first one is being treated, the newly discovered condition cannot be investigated or treated until a new referral is obtained by the patient from the GP. This causes delays and greater discomfort to the patient simply in order to assure that the reimbursement to the hospital is accurate. Patients with multiple problems, mostly the elderly, are the ones who bear the brunt of this unwise policy.

Anwar R et al. Do we neglect patients with multiple health problems? *BMJ* 2008; 2008; 336: 670.

Drug companies in the doldrums

The author enumerates the various reasons why investors find the pharmaceutical industry less attractive for investment at present. Foremost is the anticipated expiration of patents of several very lucrative drugs. Even though basic science research is increasing, it has been difficult to translate those gains into useful clinical drugs. Also, the cost of drug research is increasing, while the returns are under scrutiny from a suspicious and angry public. Recent disclosures of scandals in the pharma industry have made regulators wary of approving new drugs without an extensive investigation. This has invariably led to delays in drug approval, required greater evidence from the pharma companies, and increased the cost to the company.

Jack A. Balancing Big Pharma's books. *BMJ* 2008; 336: 418-9.

Just say you're sorry

The authors report that patient complaints have been steadily increasing over the past years. Usually they are caused by adverse events, but at times the cause is a complication expected in that particular disease. Poor communication is invariably at the root of the complaint. Most doctors find such complaints very upsetting, are unable to get the support they need to deal with it, and are worried about the legal consequences. On the other hand, most patients are not looking for legal redress, but a simple apology, and an explanation of what happened and why. Thus, the authors suggest better ways for doctors to address complaints.

Dealing with complaints. Cave J et al. *BMJ* 2008;336:326-8.

Indian clinical trials registry

This article provides detailed information on the Clinical Trials Registry - India, launched in July 2007. The CTRI is an arm of the WHO's International Clinical Trials Registry Platform. This free registry is open for registration of "any intervention conducted in India involving human participants. A registration number is given after public disclosure of all 20 items in the WHO Trial Registration Dataset. Trial registration is voluntary but necessary for submissions to journals of the International Committee of Medical Journal Editors and, now, to some journals in India as well.

Tharyan Prathap, Gehrsi Davina. Registering clinical trials in India: A scientific and ethical imperative. *Natl Med J India* 2008; 21: 31-4.

Indian journals require registration of clinical trials

The authors make a call for registration of all clinical trials being conducted in India. In 2004, the International Committee of Medical Journal Editors, a group of general medical journal editors, issued a call for the registration of clinical trials in order to increase transparency in research, ensure the publication of inconvenient trial results, support good clinical practice and protect trial subjects. Editors of these journals would consider submissions reporting on clinical trials only if the trial had been registered in a public registry that met certain minimum criteria. This would apply to trials that began enrolment after July 1, 2005. *The British Medical Journal* separately announced a similar policy. In 2007, an evaluation by the ICMJE found that trial registration was now the rule rather than the exception.

This has not been the case in India, a situation that has enabled a number of unethical trials. There is, however, hope for change in the near future. In July 2007, the Clinical Trial Registry India (CTRI) was launched. This free online registry is a WHO International Trials Registry Platform and compliant with the ICMJE requirements.

A few months after the Clinical Trials Registry - India was launched in July 2007, the CTRI in association with the *Indian Journal of Medical Research* organised a meeting of 12 editors of Indian biomedical journals. It was unanimously decided that the editors have the responsibility to promote the registration of all clinical trials being conducted in India. The editors issued a statement that from January 2010, they would consider publishing only those trials that had been registered prospectively if started in or after June 2008. Trials undertaken before June 2008 need to be registered retrospectively.

"The registration of clinical trials will help improve reliability of data generated, help clinicians interpret research, minimize duplication of trials and prevent exposure of volunteers to potential risks."

Satyanarayana K, Sharma A, Parikh P, Vijayan VK, Sahu DK, Nayak BK, Gulati RK, Parikh MN, Prati PS, Bavdekar SB, Sreehari U, Sahni P. Statement on publishing clinical trials in Indian biomedical journals. *J Postgrad Med* 2008;54:78-9.

Nutrition is a human right

This editorial comments on the Indian government's recent move to provide dry or packaged foods and biscuits in place of the hot meals supplied under its Mid Day Meals and Integrated Child Development Services. It is important because it underlines that health is more than a matter of medical services; malnutrition is a major reason for illness. It also underlines the ethical responsibility of a government towards health, equity and social justice.

The authors point out that health and education are fundamental and non-negotiable rights of every child and these rights must be supported through government policy. Indeed, the mid day meal programme was to increase the enrolment, retention and attendance of children in school leading to universalisation of primary education, improving learning and improving the nutritional status of children.

They also note that studies have proved that cooked, hot meals do more for the child's health and nutrition than supplements or dry rations which may not be eaten, or which might be taken home to share with the family, reducing the child's nutrition. "The current policy suggestion to replace cooked meals therefore calls for critical questioning from a broad public health perspective that looks at health and education in an integrated manner."

Deshpande Mita, Dasgupta Rajib, Baru Rama, Mohanty Aparna. The Case for cooked meals: concerns regarding the proposed policy shifts in the Mid-Day Meal and ICDS programs. *Indian Pediatrics* 2008; 45:445-9.

How to succeed in medicine without really trying

Many doctors in India scoff at the words "medical ethics". Why should doctors be held to higher standards than the rest of society? What' wrong with doctors making some money? And how will they make money if they don't follow the rules of the market?

This narrative is a composite of "real life" experiences by an army doctor. The author tells the story of an encounter with an old friend from medical school who initially worked in a government medical college but later moved into the private sector`. Through this account that is both tongue-in-cheek but very believable, the conversation between the author and his friend covers the gamut of malpractices as well as the standard explanations that doctors give for their decisions. Thus we hear of how doctors in the private sector must market themselves, why they refuse to treat complicated cases to maintain success rates, how to build a practice through free publicity, how to run a practice as a business and not a service, and so on. The article concludes by quoting an exchange between Alice and the Cat from Lewis Carroll's *Alice's adventures in wonderland and through the looking glass.*

Anand A C. A primer of medical practice in India. *Natl Med J India* 2008; 21: 35-9.