FROM OTHER JOURNALS

Prof. Campbell moves on[1,2]

The Bristol Medical School, University of Bristol, has inaugurated a new chair of Medical Ethics. Alistair V Campbell who was the Director of the Bioethics Research Centre [Otago, New Zealand] and Professor of Biomedical ethics from April 1990 to July 1996 is the first appointee to the chair. Professor Campbell, a theologian and a non-medical person is a well known figure in the field of bioethics. He is the founding editor of Journal of Medical Ethics and is the author of Practical Medical Ethics, Rediscovering Pastoral Care and Paid to care? The limits of professionalism in pastoral care - clearly indicating his ability and expertise in two fields which arc apparently quite diverse [1]. In an interview[2], he explained that the fundamental task of any ethics committee was to take an objective [italics mine] look at the risks and benefits of a procedure or trial. He also stated that a clinical trial was of two types - therapeutic and safety trial. In a safety trial, the aim was to confirm that a substance had no adverse side-effects and was safe; a therapeutic trial has to be beneficial to the participants. It is important to differentiate between the two for ethical reasons.

Humanities in medicine [3]

There is little doubt that the present generation of doctors are more materialistic less humane than their predecessors were. In Bombay, attempts to counter this have led to the formation of the Forum for Medical Ethics and this journal. A recent article in the Lancet suggests that the introduction of the humanities in medical studies may also make a difference. Harold Horowitz introduced poetry recitation and discussion sessions among members of his unit on his rounds. This allowed them to expand on health related aspects which are not conventionally taught during the course of a medical education as well as on life in general. His impression at the end of the sessions was that the discussion of poetry improved interpersonal relationships among team members of the unit and improved patient-doctor rapport.

Euthanasia [4,5,6]

Euthanasia is a topic that has been discussed in the columns of this journal before. We now learn that the parliament of Australias Northern Territory has passed an act that makes voluntary euthanasia legal. This act allows physicians to prescribe and even administer lethal substances to terminally ill patients who wish to end their lives. There are of course, a number of clauses to be satisfied in order to avoid mistakes or foulplay [4].

The state of Oregon, USA had passed a similar ruling in 1994, a decision which was stayed in 1995. In a study conducted among physicians in Oregon , [before the ban], 60 % thought that physician -assisted suicide should be legalised while 46 % would be willing to prescribe a lethal dose of medication, if required to do so. Surprisingly, half of all the respondents were not sure what drug to prescribe for euthanasia, nor were they confident of recognising terminal illness [less than six months to live]. Further, 28 Yc were unsure of being able to recognise depression in patients. Euthanasia, then, would appear to be a more complicated issue than expected'.

While on the subject of euthanasia, Jack Kevorkian, the American pathologist who has been aiding patients in their attempts to die without suffering, has once again been acquitted by a Michigan court. Kevorkian has assisted 28 people since 1 990 [6].

Drugs in Maharashtra [7]

An editorial in The Lancet refers to the findings of The Foundation for Research in Community Health on the provision of medicines in Satara, a district in Maharashtra state. It appears that government spending on drugs for the public sector amounted to only 2.6 % of the total drug budget for all people in Satara. The reason for this low figure is probably due to irregular supply of drugs, substandard materials, and lack of supply. For instance, Adrenaline was available for less than 25 Yo of the days in the primary health centres - a finding which does horrifies us, but does not surprise us. We are aware of larger hospitals in big cities which can boast of the same record. Is anyone listening ? The authors conclude by saying that better and continual education of medicos and paramedical staff, better drug supplies and prevention of the excessive influence of drug companies would be effective in curing more people at the same cost.

Views *on ethics* [8]

What do medical investigators in Norway think about ethics and fraud in medical research ? Jacobsen and Hals set out to find the attitudes of over a hundred investigators and learned that there was both, good as well as bad news. About 80 % felt that ethical considerations had influenced their research and 70 Yo found that the suggestions of the ethics committees were useful and relevant. The disturbing part was that only 43 Yo stated that they would never publish scientific data obtained from studies that were ethically unacceptable and a similar proportion believed that ethical considerations were sand in the machinery. The authors conclude that committees make a major contribution to quality assessment in medical science . Importantly, they, as well as many of the participants feel that the committee should also assess the scientific validity of the study.

References

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Life according to knowledge is not that which makes men act rightly and be happy, not even if all the sciences be included but... this has to do with one science only, that of good and evil. For, let me ask you... whether if you take away this science from all the rest, medicine will not equally give health?

...And yet... none of these things will be well or beneficially done, if the science of the good be wanting.

Pl... (427?-347 BC) ... *...les* 174 B (translated by Benjamin Jowett)