FROM OTHER JOURNALS

We scan the *Annals of Internal Medicine* (www.annals.org), *New England Journal of Medicine* (www.nejm.org), *Journal of the American Medical Association* (www.jama.ama-assn.org), *Lancet* (www.thelancet.com), *British Medical Journal* (www.bmj.com), *Canadian Medical Association Journal* (www.cma.ca/cmaj), *Journal of Medical Ethics* (www.jmedethics.com) and *Eubios Journal of Asian and International Bioethics* (www.biol/tsukuba.ac) for articles of interest to the medical ethics community. For this issue of the *IME* we reviewed the May–July issues of these journals. Articles of interest from the *National Medical Journal of India*, *Monash Bioethics Review*, and *Developing World Bioethics* are abstracted as and when they become available.
If you come across an article that you feel should be included, please forward it to mmamdani@comcast.net

Research

The authors provide details on how drug companies get messengers such as journalists or patient groups—apparently independent and highly credible—to promote their products. They suggest that these messengers be required to reveal conflicts of interest.

Burton B *et al*. Unhealthy spin. *BMJ* 2003;326:1205–7

The pharmaceutical industry has become the single largest direct source of funds for medical research in Canada, the UK and the US. Conflicts of interest are inevitable because the goals of the industry and that of academia differ. The author expresses concern about the increasing control of the industry on the design and publication of clinical trials, as drugs are prioritised over scientific merit.

Baird P. Getting it right: industry sponsorship and medical research. *CMAJ* 2003;168:1267

These articles describe atrocities committed by Japanese doctors during World War II, the silence among the public and academia in Japan, and the need for debate.

Tsuchiya T. In the shadow of the past atrocities: research ethics with human subjects in contemporary Japan. *Eubios Journal of Asian and International Bioethics* 2003;13:100–2

Sass HM. Ambiguities in judging cruel human experimentation: arbitrary American Responses to German and Japanese experiments. *Eubios Journal of Asian and International Bioethics* 2003;13:102–4

Thomas, M. Ethical lessons of the failure to bring the Japanese doctors' to justice. *Eubios Journal of Asian and International Bioethics* 2003;13:104–6

Nie JB *et al*. A call for further studies on the ethical lessons of Japanese doctors' experimentation in wartime China for Asian and international bioethics today. *Eubios Journal of Asian and International Bioethics* 2003;13:106–7

This article describes the angry debate generated by the publication of a study on the psychiatric consequences of abortion in low-income women. Among the questions: does ideological bias necessarily taint research? Are those who publish research responsible for its ultimate uses?

Unwanted results: the ethics of controversial research. *CMAJ* 2003;169:93

Clinical

This theme issue of the *Journal of Medical Ethics* deals with ethical challenges in organ transplants. The following articles are of particular interest:

This article describes the differences between non-heart beating dead donor and heart beating dead donor protocols and argues for defining death when irreversible asystole occurs, with the open admission that it does not define 'death' but only a moment in the process of dying when organ retrieval can be allowed.

Zamperetti N *et al*. Defining death in non-heart beating organ donors. *J Med Ethics* 2003;29:182–5

The author argues that the definition of brain death should be based on 'the irreversible loss of consciousness, which causes an irreversible absence of the capacity for integrating the main human attributes with a functioning body'. It should be considered separately from organ transplants.

In reply, Kerridge *et al* say that it is only where vital organs are sought that a diagnosis of brain death is required, and it has been necessary to legitimise the process of 'donation'. The 'dead donor rule' should be replaced with a 'good as dead donor rule' so that the process of 'donation' and transplantation becomes more honest and transparent.

Machado C. A definition of human death should not be related to organ transplants. *J Med Ethics* 2003;29:201–2

The authors argue against a proposed policy permitting removal of organs for transplant from dead people irrespective of their wishes pre-mortem.

Glannon W. Do the sick have a right to cadaveric organs? *J Med Ethics* 2003;29:153–6

The author presents arguments on why it is morally unjustifiable to increase the supply of organs for transplantation by a policy giving the sick a right to cadaveric organs. Instead he proposes a model of organ donation as a form of giving back something to the community from which one has benefited. This action is not obligatory but supererogatory—beyond the call of duty.

Hamer CL *et al*. A stronger policy of organ retrieval from cadaveric donors: some ethical considerations. *J Med Ethics* 2003;29:196–200

Mandated choice for organ donation respects individual autonomy more than any of the other strategies. The authors propose using the Spanish model where trans-

plant coordinators are charged with gaining the consent of relatives for organ donation by persuasion if necessary. Individuals who choose not to donate need not justify their decision in a public investigation.
Chouhan P *et al*. Modified mandated choice for organ procurement. *J Med Ethics* 2003;29:157–62

The authors argue for the use of tissue left over after diagnosis for educational and scientific purposes.
van Diest PJ *et al*. Cadaveric tissue donation: a pathologist's perspective. *J Med Ethics* 2003;29:135–6

The author points out that the act of asking a patient or relative for organ donation puts an immense emotional demand on the doctor who is designated to do so. Acknowledging this as an altruistic act, rather than dismissing it as part of their job, will support and encourage the doctors.
Kirklin D. The altruistic act of asking. *J Med Ethics* 2003;29:193–5

The author gives reasons based on the Philippine culture why prisoners should be allowed to donate organs for transplantation and proposes safeguards to ensure that their vulnerability will not be exploited.
de Castro LD. Human organs from prisoners: kidneys for life. *J Med Ethics* 2003;29:171–5

The authors dispute the assumption that genetically unrelated donors are much more vulnerable to coercion than are related donors, and hence are more in need of protective regulation.
Choudhry S. *et al*. Unrelated living organ donation: ULTRA needs to go. *J Med Ethics* 2003;29:169–70

In a well-known British case, the relatives of a dead man consented to the use of his organs for transplant on the condition that they were transplanted only into white people. The British government panel condemned all conditional offers of donation and appealed to a principle of altruism and meeting the greatest need. This paper criticises their reasoning saying that while this racist condition was wrong, all conditions are not necessarily so.
Wilkinson TM. What's not wrong with conditional organ donation? *J Med Ethics* 2003;29:163–4

The authors propose a market in organs from living donors. They suggest features to protect exploitation such as a single buyer such as the National Health Service, donors and recipients must be residents of the same country, etc. Also they propose adequate compensation to the donor who is otherwise the only person currently not receiving any.
Charles A Erin, John Harris. An ethical market in human organs. *J Med Ethics* 2003;29:137–8

Is selling body parts wrong in itself, irrespective of the consequences? Will the harm outweigh the benefits? The authors argue that there is a case for allowing sale of organs, but they also state that a totally free market could do a great deal of harm.
Richards JR. Commentary. An ethical market in human organs. *J Med Ethics* 2003;29:139–40

The following two articles deal with human rights of sex workers:

Sex work is often regarded as a behaviour, not an occupation. As a result, sex workers are often not involved in discussions of their conditions of employment.
Loff B *et al*. Can health programmes lead to mistreatment of sex workers? *Lancet* 2003; 361:1982

A rights-based approach should be used to promote the health of sex workers and not merely to slow down HIV dissemination.
Wolffers I *et al*. Public health and the human rights of sex workers. *Lancet* 2003;361:1981

The author describes the confusion, anxiety and errors that occurred in Taiwan during the recent SARS epidemic and raises ethical questions regarding stigma, quarantine and its effects, professionalism of the medical staff, penalties for violators of quarantine, etc.
Hsin DH. SARS: an Asian catastrophe which has challenged the relationships between people in society: my experience in Taiwan. *Eubios Journal of Asian and International Bioethics* 2003;13:107–8

This theme issue of the *BMJ* discusses death and dying:

Before any legislation is enacted, more research is needed to explore and represent patients' views on end-of-life care.
Mak YYW *et al*. Patients' voices are needed in debates on euthanasia. *BMJ* 2003;327:213–15

Care for dying patients needs to respect the views of people from different faiths and cultures.
Neuberger J. A healthy view of dying. *BMJ* 2003;327:207–8

In decisions to withhold treatment in non-emergency settings, there is more time available and the patient can be better prepared. In emergency situations, withholding treatment cannot be done in a controlled way. The author describes a case in which even a terminally ill patient and family needed time to prepare for death.
Saunders Y *et al*. Planning for a good death: responding to unexpected events. *BMJ* 2003;327:204–6

The author discusses how concepts about a good death depend on the extent of secularisation, individualism and how long the typical death takes. These change over time.
Walter T. Historical and cultural variants on the good death. *BMJ* 2003;327:218–20

The best remedy for reducing the risk of diarrhoea is handwashing with soap. The authors argue that in a partnership with the private sector to glamourise hand-washing with soap, the government can more effectively promote hygienic practices while allocating its scarce resources elsewhere.

Curtis V *et al*. Water, sanitation, and hygiene at Kyoto: handwashing and sanitation need to be marketed as if they were consumer products. *BMJ* 2003;327:3–4

Health policy

Till date no law has effectively dealt with medical futility. Courts had generally let the family decide even if medical professionals stated that the treatment was futile. The authors describe the steps to be followed in such an end-of-life medical futility dispute.

Fine RL *et al*. Resolution of futility by due process: early experience with the Texas Advance Directives Act. *Ann Intern Med* 2003;138:743–6

In a no-fault liability system the claimant must show that the medical error was a causative factor in the resultant injury, irrespective of who is to blame (proof of causation rather than proof of fault). In this system negligent professionals would not escape punishment.

Gaine WJ. No-fault compensation systems. *BMJ* 2003;326:997–8

Patients need access to high-quality balanced, and accurate information in an easily understandable format. However, pharmaceutical advertising is designed to 'sell' a product, and highlight the benefits while playing down the risks.

Garlick W. Should drug companies be allowed to talk directly to patients? NO. *BMJ* 2003;326:1302–3

The drug industry remains the only industry where companies are forbidden from communicating with individual customers about their products, which the industry claims to do in an ethical and scientific manner. Patients are not always given information about appropriate treatments that are deemed 'too expensive.' It may cost more but the patient may consider that price worth paying.

Jones T. Should drug companies be allowed to talk directly to patients? YES. *BMJ* 2003;326:1302

Interactions between doctors and drug companies can lead to ethical dilemmas. This article gives an overview of the guidance and codes of practice that regulate the relationship.

Wager E. How to dance with porcupines: rules and guidelines on doctors' relations with drug companies. *BMJ* 2003;326:1196–8

The author describes the debate in the scientific community and the public about cloning, which centres on whether human cloning may be facilitated by allowing research on stem cells.

Daley GQ, Cloning and stem cells: handicapping the political and scientific debates. *NEJM* 2003;349:211–12

Education

The author argues that the entanglement between doctors and drug companies is widespread and a culture of industry gift giving creates entitlements and obligations that conflict with the primary obligation to patients undermining rational prescribing strategies.

Moynihan R. Who pays for the pizza? Redefining the relationships between doctors and drug companies. 1: Entanglement. *BMJ* 2003;326:1189–92

While medical reform groups call for independent education and sources of information, the drug industry defends the value of its educational sponsorship to patients and rejects the idea of disentanglement.

Moynihan R. Who pays for the pizza? Redefining the relationships between doctors and drug companies. 2: Disentanglement. *BMJ* 2003;326:1193–6

Not only free newspapers for doctors but medical journals too depend on income from pharmaceutical advertising, which is often misleading. Editorial coverage can also be manipulated in many ways to give results that are favourable for the drug companies.

Smith R. Medical journals and pharmaceutical companies: uneasy bedfellows. *BMJ* 2003;326:1202–5

An article on the ethics of intimate examinations without consent attracted powerful comment. This summary of rapid responses to the article notes that almost all those who mentioned it said that it was unethical and must stop. No one could explain why it endured, only a handful tried to defend it. A few others, while not defending examination without consent, wondered why rectal, vaginal and breast examinations were such a special case. Contrary to this, patients were less likely to share these views. One respondent suggested that consultants who thought that intimate examinations were not especially intimate should hand over their own body parts for examination by medical students. How can we resolve the special ethical pitfalls surrounding intimate examinations? First, medical students should be taught using mannequins and volunteers, rather than patients. Second, students and patients might be more confident (and less embarrassed) if students had a clearer and better respected place in the medical team, including being covered by the team's consent procedures. Third, we could teach intimate examinations only to postgraduates who need to know, not to undergraduates or to postgraduates who will never need those skills, says a consultant paediatrician. Finally, perhaps we should stop doing intimate examinations altogether. 'We do these examinations because we have 'always done them' and their importance is over-stated.'

Tonks A. Please don't touch me there: the ethics of intimate examinations. Summary of rapid responses. *BMJ* 2003;326:1327