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 *IJME* we reviewed the August–October 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

Can risk information harm the patient?

Can prevention of harm pose ethical questions? The following article questions rigid adherence to preventive medicine guidelines. More people in India now expect their doctors to be knowledgeable about prevention measures. Thus, a sceptical view should give us food for thought.

Extensive implementation of preventive medical measures is becoming unmanageable as these take up an extensive amount of consultation time. However, failure to follow preventive guidelines is considered a sign of low-quality care. Doctors may not have the time or ability to effectively communicate clinical risks. They may also have doubts about interventions which are effective in optimal settings but may be of marginal benefit in everyday practice. Health is affected by external factors, such as social inequality and destructive human relations. Finally, there is an ethical concern regarding the effect of preventive medicine on individuals.

Information about risk will increase people's sense of control and ultimately their quality of life. However, risk information may create doubt and insecurity. Once such information is passed on to a person it cannot be retracted. Respect for autonomy should therefore also honour the person's right not to be opportunistically confronted with knowledge about risks unrelated to the reasons for seeing the doctor. While it is certainly good medical practice to identify, emphasise, and support health-promoting resources, skills, and activities, doctors should increase patient autonomy by inviting the patient to introduce a topic rather than using a computerised prevention guideline.

Is opportunistic disease prevention in the consultation ethically justifiable? Getz L *et al*. *BMJ* 2003;327:498–500.

Resuscitation of the terminally ill

Increasingly, patients with terminal illnesses are dying in hospitals rather than at home. Therefore, it is important to be aware of the controversies discussed in the articles below. Some of these are: How much should a physician share with the patient and family? Who makes decisions: the patient or family? At present, India does not have legally binding Do Not Resuscitate (DNR) or No Emergency cardiopulmonary resuscitation (CPR) directives but there is a growing need for such a law.

Terminally ill patients often have to make decisions about their final treatment after a protracted period of illness. Discussion about CPR is as important as discussion about any other treatment, and should be done early. Some doctors avoid talking about DNR because they feel it is important to offer a positive outlook. However, the alternative is that doctors use their judgement in making this decision based on their assumption about the patient's quality of life and this assumption may be inaccurate. A study of chemotherapy preferences among patients with advanced lung cancer found that although all had received chemotherapy, only a quarter would make the same decision again had they been more fully informed. When patients become aware of the low probability of success of CPR, many are less likely to request it.

Higginson IJ. Doctors should not discuss resuscitation with terminally ill patients. —AGAINST. *BMJ* 2003;327:615–16

Patients increasingly want to participate in decisions about their treatment. Although this is appropriate in most circumstances, discussing CPR with terminally ill patients is not practical, sensible, or in the patient's best interests. Patients need to maintain some hope—if not for a cure then at least for some comfort. All comfort should not be lost as a result of the inappropriate blanket application of a facile rule. This is particularly true when the rule forces patients to make a choice, when in reality they have no choice. Another argument for not discussing CPR with terminally ill patients is medical futility. When people are dying, it is entirely ethical not to discuss resuscitation with them.

Manisty *et al*. Doctors should not discuss resuscitation with terminally ill patients—FOR. *BMJ* 2003;327:614–15

The authors wished to identify themes in the existing literature that could be used to guide physicians in the discussion of CPR with hospitalised elderly patients at risk of death. Most patients reported getting much of their knowledge about CPR from television which portrays a high success rate for resuscitation. However, patients' comprehension of most facets of CPR was poor. Willingness

of physicians to initiate discussions about CPR appeared to be the main factor that determined whether such discussions occurred. The most common reasons cited for not reviewing CPR preference were the patient not being ill enough, the possibility of the discussion upsetting the patient, and the physician's discomfort with the process. The majority of older inpatients preferred to be involved in discussions about CPR. The authors suggest that physicians must initiate these discussions with older patients, recognising that the decision-making process may be complicated by cognitive impairment and necessitate the presence of family members or substitute decision-makers.

Frank C *et al*. Determining resuscitation preferences of elderly inpatients: a review of the literature. *CMAJ* 2003;169:795–799

What do patients want?

Patients often complain that doctors rarely spend adequate time talking to them. We need a study like the one below to ascertain the wishes of our patients on how, what, when and where our patients would like their doctors to communicate with them.

The authors searched the literature for articles with descriptions of patient participation in treatment decisions. They concluded that patients want to be involved in decision-making ('selecting the most desired bundle of outcomes') but leave the problem-solving ('identifying the one right answer') to the doctor as it requires clinical expertise. Most patients want doctors to understand their preferences even if they do not wish to make the final decision. Enabling patients to understand risks is crucial before considering different treatment options. Yet, risk is a complex phenomenon that many patients (and doctors) find difficult to understand and doctors must realise that some patients are unable to cope with uncertainty. Patient preferences may be dictated by alternative sources of information which may be resented by the doctor. Doctors may have trouble eliciting patient preferences as these are influenced by the way that they are elicited, and doctors may elicit preferences from certain groups of patients more readily than others.

Say RE *et al*. The importance of patient preferences in treatment decisions—challenges for doctors. *BMJ* 2003;327:542–45

When the doctor is also a writer

IJME publishes and solicits articles on medical ethics from people involved in the medical profession. This article raises pertinent questions about the ethics of writing about patients.

Physician-writers have obligations to their patients and as writers to their readers. The first category, keeping faith with the patient, includes privacy, consent and consequences. The second category, keeping faith with the reader, includes the issue of fact or fiction, and transparency in disclosure. The authors cite examples to illustrate the dilemmas involved.

Coulehan J *et al*. Keeping faith: ethics and the physician-writer. *Ann Intern Med* 2003;139:307–311

Suicide information on the Internet

While the Internet facilitates gathering information, the quality and content do not always serve societal interests. The following article from India is a laudable attempt to limit harmful content on the net.

Information on the Internet promoting deliberate self-harm is a little discussed subject. The author searched the net and found several websites that give detailed information on how to commit suicide by a variety of means. He discusses the ethical concerns of having this information available readily to vulnerable populations. He describes the setting up of a database, E-Health Adversities Research Database, that collects, analyses and publishes evidence regarding adverse health information and practice over the Internet, to help formulate future policy.

Scaria V. A discussion on the perspectives of suicide related information on the Internet. *Eubios Journal of Asian and International Bioethics* 2003;13:175–6

Problems in AIDS research

Indian scientists are preparing to launch Phase I of an indigenous AIDS vaccine. Reports in the lay media and medical journals, while acknowledging the need for multinational trials, warn about the exploitation of uninformed patients by western pharmaceutical companies. The need of the hour is to ensure adequate protection of the rights of trial participants so that an effective remedy against AIDS is available in the near future.

A worldwide effort is needed to develop effective AIDS vaccines. The debate on the ethics of conducting an AIDS vaccine trial raises difficult issues such as adequate informed consent, and treatment for trial participants who become infected by HIV during the trial. The author argues that requiring researchers to provide lifetime care is a disincentive for such trials. Instead, by adopting a developmental approach, participating communities would receive priority in national and international programmes because they are contributing knowledge that is a global public good.

Berkeley S. Thorny issues in the ethics of AIDS vaccine trials. *Lancet* 2003;362:992

International trials raise ethical concerns because of great disparities in wealth, power, and medical infrastructure and a history of exploitation. By inclination and training, researchers may want to focus on the technical aspects of designing protocols and analysing data. However, researchers conducting clinical trials in developing countries have ethical obligations beyond those falling on researchers working in the developed world. The

authors describe ways in which researchers can address these concerns.

Lo B *et al*. Establishing ethical trials for treatment and prevention of AIDS in developing countries. *BMJ* 2003;327:337–9.

This editorial discusses the World Medical Association's postponement of a proposed amendment to the Declaration of Helsinki, concerning treatment provision after a study ends. In particular, the amendment would be relevant in HIV vaccine trials in the developing world, to ensure access to the 'best proven' therapy identified in a study.

The writer states that opposition to the amendment is led by the US government and western pharmaceutical companies who feel it unfairly burdens researchers and their sponsors with responsibilities that should lie with the local healthcare system. 'Paragraph 30', the proposed amendment, embodies a non-negotiable principle preventing exploitative research in developing countries.

One standard, not two [Editorial]. *Lancet* 2003;362.

Should rich countries recruit doctors from poor countries?

Physician migration agitates the lay public and medical professionals. Is it ethical for doctors to migrate? Are migrating physicians more ethical than their colleagues who accommodate to the less than ideal setting in India? Reasons for migration are a complex mix of the personal and professional. The following debate gives two views and additional opinions are available in the issues of BMJ. The first author practises in the UK, while the second is an official of the National Health Service (NHS), UK.

The NHS has launched a scheme to recruit specialists from developing countries for a two year period. The writer notes that most doctors in developing countries are trained in publicly funded medical schools. The cost of training is borne by the poor country and the rich country reaps the benefits. What is needed is an acknowledgement that institutions in developed countries have an ethical obligation to facilitate the return of health professionals to developing countries. Also, doctors going to work overseas must search for ways to share their expertise and resources. At the same time, institutions in developing countries must acknowledge that doctors leave not only for monetary gain but also to escape stifling hierarchies.

Patel V. Recruiting doctors from poor countries: the great brain robbery? *BMJ* 2003;327:926–8

The writer states that the international fellowships were launched in February 2002 to give experienced consultants the opportunity to work in the NHS for two years. The National Health Service does not recruit from a country if its government has any concerns about the effect on its workforce. It worked closely with the Indian Ministry of Health in the development of the campaign in India, and is working with India and other developing countries to support them in developing programmes, including offers of fixed term placements in the NHS as part of career planning to retain their staff.

Mellor D. Recruitment is ethical. *BMJ* 2003;327:928

The industry targets women

On the one hand women have been excluded from research and the results of studies done on men are applied to women as well. On the other, the drug industry has targeted women as a special 'market'. This editorial reviews direct-to-consumer promotion of drugs, noting that many of these are targeted at women.

A review of magazine advertising found that whenever there is sex-specific targeting, women are 2.6 times more likely to be targeted than men are. Normal life stages such as the menopause are medicalised—what is described as the 'diseasing of risk factors'—fear is generated about fractures and heart disease, and the drugs are promoted as life-saving as well as rejuvenating. Women are also more likely to be prescribed psychotropic drugs when the diagnosis did not warrant it—and when these drugs had not been tested on women in the first place. The writer concludes that the campaign against irrational drug promotion must also address its social and health effects, affecting women differently from men.

Mintzes Barbara. Women and drug promotion: the "essence of womanhood is now in tablet form". *Bodhi* 2003;51:1–5. Abridged from *Essential Drug Monitor* 2002;31:12–13

Doctors and drug companies

This narrative describing an encounter between a senior medical professor and a former student who now heads a contract research organisation (CRO) highlights the uncomfortable links between the medical profession and the drug industry in India. Set in the backdrop of a medical conference-jamboree where, apparently, doctors do everything but learn about medicine. The conversation illustrates the various things CROs do to sponsor drug research done by doctors. In exchange doctors get 'auxiliary support' and more. As the CRO's MD is quoted: 'You old-fashioned people will be surprised to learn what doctors are willing to do for paltry sums.' Her parting lines: 'Look at this conference 'APICON' *you* doctors have organised. *You decide* to have a banquet in a five-star hotel and *you demand* money from multinational PIs.' The writer is left speechless: 'I kept searching for words to defend my community of doctors against her community of business interest.'

A C Anand. New managers for medical research: superspecialists or middlemen? *Nat Med J India* 2003;16:216–219