Letters

Medical ethics, the Israeli Medical Association, and the state of the World Medical Association

Open letter to the BMA

EDITOR—Persistent concerns have been raised about the role of the World Medical Association (WMA), the international watchdog on medical ethics, in respect of their approach to the Israeli Medical Association (IMA) in particular.[1] Matters have now come to a head with the news that Yoram Blachar, longstanding IMA president, has been elected as chairman of the WMA council.

The WMA must know the well founded criticism over many years of the medical ethical track record of the Israeli Medical Association (IMA). In 1996 Amnesty International concluded that Israeli doctors working with the security services "form part of a system in which detainees are tortured, ill treated, and humiliated in ways that place prison medical practice in conflict with medical ethics."[2] Other major human rights organisations, such as Physicians for Human Rights (USA) and Human Rights Watch, published similarly. The IMA did nothing, although when challenged tended to dismiss criticism as "political" and point to their membership of the WMA as evidence of their probity. Moreover Blachar is on record in the *Lancet* as defending "moderate physical pressure" during the interrogation of Palestinian detainees: it is not often that the president of a national medical association uses a medical journal to defend what the rest of the world, and the UN Committee Against Torture, regarded as torture.[3] Thus the IMA have been in violation of the WMA's Declaration of Tokyo, which forbids the involvement or collusion of doctors with torture or other cruel, inhuman, and degrading procedures. The WMA has consistently chosen to ignore the mass of documentation pointing this way.

During an interview in 1999 with a delegation from the Medical Foundation for the Care of Victims of Torture, London, the then head of ethics of the IMA, E Dolev, stated openly that "a couple of broken fingers" during the interrogation of Palestinians was a price worth paying for information.[4] This was sent to Delon Human, WMA secretary general, whose response was telling. He wrote back to say, "I must come to the defence of the IMA in affirming that they are co-signatories of the WMA Declaration of Tokyo. They have been active collaborators in the WMA's continued struggle to eradicate torture of any kind in prisons or other settings all over the world" (personal communication, 29 October 2001). He later added that he had spoken to Blachar, already a WMA council member. Blachar had reassured him that the IMA had done nothing wrong and had shown him "classified material," presumably from military sources. It is preposterous that Human was satisfied by this.

The other major ethical issue is medical neutrality. The blatant and apparently systemic disregard shown by the Israeli defence force during its reoccupation of the West Bank early last year and subsequently, has been widely reported: Palestinian ambulances fired on (231 incidents to date) and their personnel killed, sometimes after the ambulances had been cleared for safe passage, the International Committee of the Red Cross and other aid agencies obliged to limit activities in the West Bank as a result of threats to staff and attacks on vehicles and officers, severely injured Palestinians dying of blood loss because their relatives were not permitted by Israeli soldiers to take them to hospital, the safe passage of emergency supplies of food and medicines blocked, wilful destruction of water supplies, electric power, and the public health and medical infrastructure. Blachar's response to an editorial in the *Lancet* last year on these events makes his and the IMA position clear.[5 6] Bar a one sentence reference to the principle of medical neutrality, he emphatically attacked the editorial en bloc and unconditionally defended the behaviour of the Israeli army. He implies that the death of Palestinian civilians was not morally equivalent to the death of Israeli civilians: this dehumanisation is the enemy of any universal application of medical ethics and medical humanitarianism.

A recently published report by Physicians for Human Rights Israel (PHR, www.phr.org.il) states that "we believed that the IMA might be able to curb the appalling deterioration in the attitude of Israeli military forces towards Palestinian health and rescue services. Yet despite severe injury to medical personnel and to the ability of physicians to act in safety to advance their patients' interests, despite Israeli shells that have fallen on Palestinian hospitals, despite the killing of medical personnel on duty—IMA has chosen to remain silent."[7] The IMA has refused to answer any of PHR's detailed complaints. Hadas Ziv of PHR Israel charged in the *Lancet* recently that the IMA was merely an executive arm of the Israeli establishment, working to support political imperatives rather than serving universal medical ethics.[8]

It seems to many that it is PHR Israel not the IMA who are the upholders in Israel of what the WMA exists for. Thus I question the judgment and rigour of Human in his scarcely credible public defence of the IMA, and of Blachar, whose presence at the WMA affords him the opportunity to "explain" why the IMA should not be the subject of serious scrutiny. For Blachar to now take up the chairmanship of the WMA Council is to reduce things to a mockery of what was intended when the WMA was created in 1947.

Until now the BMA has relied on discreet methods but these have not worked. Once before the BMA took a robust approach—in relation to the Medical Association of South Africa (MASA) during the apartheid era—and for a time withdrew from the WMA in protest at their re-admittance of the MASA. The BMA surely needs to use its weight to confront the WMA leadership and the IMA. Things cannot go on like this: please act on our behalf. For a start, Blachar cannot remain as chairman.

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1 Summerfield D. What is the WMA for? The case of the Israeli Medical Association. *Lancet* 2003;361:424.
2 Summerfield D. Medical ethics: the Israeli Medical Association. *Lancet* 1997;350: 63.
3 Blachar Y. The truth about Israeli medical ethics. *Lancet* 1997;350:1247.
4 Bamber H, Gordon E, Heilbronn R, Forrest D. Attitudes to torture. *J R Soc Med* 2002;95;271-2.
5 Failure to address the health toll of the Middle East crisis. *Lancet* 2002;359:1261.
6 Blachar Y. Health toll of the Middle East crisis. *Lancet* 2002;359:1859.
7 Physicians for Human Rights. A legacy of injustice: a critique of Israeli approaches to the right to health of Palestinians in the Occupied Territories. Israel: Physicians for Human Rights, 2002:74..
8 Ziv H. The role of the Israel and World Medical Associations. *Lancet* 2003;361:1827-8.

Reply from the BMA

EDITOR—Summerfield's open letter is addressed to three organisations, and the BMA can speak only for itself. I agree with several points he raises. Firstly, I agree that the mere fact of membership of the World

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Medical Association is not necessarily any guarantee of exemplary ethical conduct. There are good arguments for maintaining an inclusive international organisation that seeks to influence medical associations positively by exposing them to best practice rather than excluding and isolating them.

I agree that reports from organisations such as Amnesty International have indicated problems in Israel, but such reports also show that no country on earth has a blameless human rights record. (The BMA's own human rights report of 2001,[1] discussed examples of abuse of human rights, involving doctors as victims, witnesses, or collaborators, in over 100 countries. Abuses range from medical participation in capital punishment, judicial amputations, floggings, and torture through to "routine" acts of female genital mutilation or neglect of prisoners.) This is only a partial picture of the reality of human rights violations worldwide. Many WMA member countries clearly have human rights problems, and it is not always clear what action members should take to address these.

Summerfield is correct in saying that the BMA left the WMA after the Steve Biko affair in the apartheid era. The BMA was then unable to influence the development of WMA policies. Considerable discussion took place about the pros and cons of membership before we rejoined the WMA; wielding influence was a major factor in the decision to rejoin.

A main theme of the BMA's latest human rights book is facilitating change through education, support, and publicising best practice. The democratic view in the WMA is that encouragement to improve is likely to have more success than mere condemnation and is one reason for its admitting the China Medical Association into membership. By raising awareness among medical leaders, the hope is that doctors will ultimately have a positive human rights influence in the communities in which they work. But this is a long process, and there are no easy solutions.

This is not to deny the importance of thorough investigations of all allegations of malpractice or culpable inaction concerning doctors in any country by an appropriately resourced and independent expert body. I agree with Summerfield that such investigations should happen wherever allegations arise, but the problem is to identify by whom. We already have international human rights machinery through the United Nations. Although it may not always be effective, it is hard to see how it could be superseded. Therefore, the BMA has consistently highlighted the crucial role of the UN system of human rights rapporteurs. Problems of access to healthcare services and safe passage of ambulances, for example, are issues that the BMA has drawn to the attention of the new UN Rapporteur on the Right to Health along with examples of other obstacles to health care in many other countries.

Although we are not a human rights campaigning organisation, the BMA has a good record on raising awareness of human rights standards among doctors. We lack the means, the expertise, and the hubris to measure and assess the performance of other national medical associations. The aim of our human rights focus has been to encourage doctors and medical associations to address, where they can, factors that give rise to abuse but not to act as policeman, judge and jury.

I acknowledge that there are different opinions on this subject, and, through lengthy correspondence, Summerfield and I have taken differing views on what could effect change. He has a passionate belief in human rights, which commands respect. The BMA would rather work with him to promote human rights than argue about methods. It is not obvious how exclusion of the IMA—and presumably of many more associations that stand accused of being passive collaborators in systematic human rights abuses in their own countries—will improve the situation. Through regular and robust debates on ethics and human rights, the BMA and the WMA raise awareness among medical associations of international human rights standards more effectively than a system of criticism and boycotts of any medical association.

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1 British Medical Association. *The medical profession and human rights: handbook for a changing agenda.* London: Zed Books, 2001.

Images of war: patients' best interests are paramount

Editor—The Council on Ethical and Judicial Affairs of the American Medical Association strongly supports Singh and DePellegrin's condemnation of filming patients affected by war without consent.[1] The medical profession must preserve the ethical tenets of privacy, confidentiality, and consent of patients in times of both war and peace. In this regard, the council recently established ethical guidelines about the filming of patients (Council on Ethical and Judicial Affairs, report, American Medical Association annual meeting, Chicago, June 2003).[2]

Doctors should not permit commercial filming, such as Al-Jazeera's use of graphic images associated with war, without patient consent.[2] In educational settings educational benefits may be lost if filming does not occur. In such circumstances it may be permissible to allow filming without the prior consent of the patient, but consent must still be obtained before using the film (Council on Ethical and Judicial Affairs, report, American Medical Association annual meeting, Chicago, June 2003).

Differences between educational and commercial filming stem from the protections provided when filming is conducted by healthcare professionals, who are ethically bound to protect patient privacy and confidentiality of patient information.

Various pressures may be placed on doctors to compromise their commitment to ethics. However, only by keeping patients' best interest as their paramount responsibility will doctors preserve the integrity of their professional relationships with patients and continue to earn public trust.

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Competing interests: None declared.

1 Singh JA, DePellegrin TL. Images of war and medical ethics. *BMJ* 2003;326:774-775. (12 April.)
2 American Medical Association. *Opinion 5.045. Filming patients in health care settings. Code of medical ethics.* 2002-2003 ed. Chicago: AMA, 2003.

Tackling India's HIV epidemic

HIV drugs support HIV prevention work

Editor—Potts and Walsh debate how to tackle India's HIV epidemic.[1] It is not people from the rich country lobby who are calling for treatments but the many thousands of people positive for HIV in poor countries who demand equity of access to life saving treatments.

The provision of antiretroviral drugs in a framework of an expanded comprehensive response to the epidemic is important for many sound reasons. Even putting the human rights and ethical arguments to one side, the infrastructure and economic development of many African countries has been utterly devastated by the pandemic.[2] The fabric of many societies is being eroded, and children are growing up as orphans, with all the social and individual consequences this brings. Prevention work, without access to treatment, means that individuals have little incentive to seek voluntary counselling and testing, and those identified become stigmatised. As we saw in the late 1980s and early 1990s people are reluctant to test if there are no available treatments.[3 4]

Provision of low cost antiretroviral drugs should therefore be viewed as part of the integrated response to the HIV pandemic—integrated with prevention and building on established treatment and care programmes and HIV mother to child transmission prevention programmes.

Sadly the lack of adequate funding for what will ultimately be one of the biggest threats to global security[5] means that the polarised debate on prevention *v* treatment will continue. There should be neither prevention programmes unlinked to antiretroviral drugs nor treatment programmes unlinked to prevention.

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Competing interests: None declared.

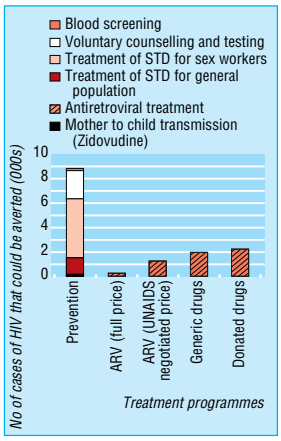
1 Potts M, Walsh J. Tackling India's HIV epidemic: lessons from Africa. *BMJ* 2003;326:1389-92. (21 June.)
2 Susman E. AIDS drops life expectancy in 51 nations. *United Press International Science News* 2002;7 July. www.aegis.com/news/upi/2002/UP020705.html (accessed 26 Jun 2003).

3 Klosinski LE. HIV testing from a community perspective. *J AIDS* 2000;25(suppl 2):S94-6.
4 Anonymous. Don't take the test. *Optimist* 1985:4. (AIDS Project/Los Angeles.)
5 Schneider M, Moodie M. *The destabilizing impacts of HIV/AIDS.* Washington, DC: CSIS, 2002. www.csis.org/africa/0205_DestImp.pdf (accessed 6 Aug 2003).

India should disregard advice

EDITOR—Although Potts and Walsh's article is a timely reminder of the issues at hand, the solutions provided are not evidence based and are indicative of patronising assumptions.[1] Indian policy makers should disregard the condescending recommendations put forward by the authors.

The article lacks empirical understanding of the sociocultural determinants and consequences of HIV infection in India, and the argument is fraught with conceptual poverty. Culturally insensitive recommendations expose the authors' ignorance about the complex social and cultural history of Hindus and Muslims in the subcontinent. Those who are familiar with the ground level, lived experience, or have access to large amounts of empirical data on the complexity of HIV infection in India would know that mathematical models might not be able precisely to predict the cultural and social complexity of risk and risk behaviours in India.



The focus of intervention should therefore be on people and communities that are vulnerable to HIV infection, and it should be evidence based. It should also be on enhancing access to care and treatment for people living with HIV/AIDS. In addition, advocacy for increased use of generic antiretrovirals is essential, and India has the technical ability to produce generic antiretrovirals, which should be encouraged and legally protected from international trade bullying. Potts and Walsh do not present a compelling argument against facilitating treatment benefits to people living with HIV in India.

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1 Potts M, Walsh J. Tackling India's HIV epidemic: lessons from Africa. *BMJ* 2003;326:1389-92. (21 June.)

Is testing everyone for HIV logical?

EDITOR—Ammann in his editorial on preventing HIV is either being deliberately provocative or has got it entirely wrong.[1] Testing everyone for HIV, regardless of perceived risk factors, to break down the barrier that HIV only affects "us" and not "me," is likely to do exactly the opposite. Labelling people as "having" and "not having" foments discrimination: it does not dispel it.

Given the seroconversion window of three months, does Ammann expect everyone to be tested on a permanent three monthly cycle to close the loop? Such impractical suggestions that promote discrimination show blindness to what is going on in society in general. In Cuba, HIV infected people have been imprisoned "for the public good," and in Africa the denialists rule countries and opinion.

Furthermore, patients with HIV can be denied entry to visit Ammann's own country, the United States, by law.

Without the offer of political education and further funding, to provide a viricidal agent as opposed to an enzyme inhibiting virostatic one, suggesting mass testing is as illogical as it is impractical. Why test masses of people, label them, but offer no chance of a cure, let alone clinical management? Such an approach while being morally bankrupt in the face of confidentiality leads to more despair.

Ammann's strategy should be to pursue political education and funding for viricidal solutions before offering mass screening for an incurable condition. His motives for suggesting such a strategy may have logic but lack a practical outcome in the absence of a cure or appropriately funded management programmes. However, if he believes that regular and persistent testing is the way forward he may wish to declare his own HIV status publicly, today, in three months, six months, nine months, etc.

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1 Ammann AJ. Preventing HIV. *BMJ* 2003;326:1342-3. (21 June.)

Surgeon specific mortality in adult cardiac surgery

Quality of data is important

EDITOR—I fully support the use of risk stratified mortality data in preference to crude mortality data if surgeon specific comparisons are to be published. The quality of such information depends on the rigour with which data are collected. Bridgewater et al took great care to ensure completeness and accuracy of data, including prospective collection of data, such that only 2% of data were missing. This adds considerable weight to their conclusions.[1]

If such methods are to be used nationally, there must be equally robust validation of the data collection process in all institutions to prevent potential information bias. There is a danger that data will be collected retrospectively, and the investment in, and quality of, coding and record keeping varies greatly between institutions. For example, the absence of data on comorbidities or the failure to code them will result in a low estimate of expected mortality and falsely suggest a poorer surgical performance.

Should this approach be adopted, robust evidence of data completeness and accuracy should be a prerequisite before data are accepted from any institution to ensure that surgical performance is being compared, not administrative capacity.

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Higher risk cases need also to be assessed

EDITOR—Risk adjusted outcomes are essential in interpreting surgeon specific mortality, but Bridgewater et al say that such adjustments do not discriminate in low risk patients (the majority) when baseline mortality is very low.[1] They claim that the differences in surgeons' crude mortality rates are explained by variation in the case mix of high risk patients, which is not amenable to risk stratification. However, true differences are probably detectable only in this group.

An underperforming surgeon is likely to create most havoc in this group of patients. Bridgewater et al recommend "a comparative analysis based on low risk cases without the need for further risk adjustment." All this will achieve is to show that all surgeons fall within two standard deviations of the mean for the average case. Take another pat on the back.

Knowing each surgeon's risk adjusted performance for the high risk cases would be interesting as it may well mirror their performance in the crude, non-adjusted rates and therefore show that crude death rates are indeed the most accurate way to proceed.

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1 Bridgewater B, Grayson AD, Jackson M, Brooks N, Grotte GJ, Keenan DJM, et al. Surgeon specific mortality in adult cardiac surgery: comparison between crude and risk stratified data. *BMJ* 2003;327:13-7. (5 July.)

Surgeon is only one influence on outcome

EDITOR—Carter's editorial on the surgeon as risk factor is an interesting assessment of the various determinants of surgical outcome.[1] The surgeon is not, however, an isolated factor but one of many interrelated factors determining surgical outcome. Good surgical results are the result of interdependent multiple factors, including anaesthetic, intensive care, medical, nursing, and paramedical support, and a culture in search of excellence.

The most important progress in the surgical management of patients during the past 100 years has resulted from non-operative components of surgical care: anaesthesia, antisepsis, and asepsis. However, just as all credit for success should not be attributed to the surgeon, neither should all the failure.

Surgeons and patients like to think that the surgeon is the most important ingredient in the surgical outcomes cake. That surgeons account for many referrals to the National Clinical Assessment Authority in England and the Health and Disability Commissioner in New Zealand is therefore perhaps not surprising.[2 3] Focusing on the individual surgeon, however, is often a short sighted and simplistic assessment of the situation.

Technical skill, although very important, cannot overcome poor case selection or inappropriate indications for surgery. The structure of the clinical systems put in place in a clinical team and the culture of the unit can help to ensure that clinical decisions are correct.

If you take a surgeon with excellent clinical results and put him or her where the results are poor the change of surgeon alone is unlikely to produce a significant change in results. To isolate the surgeon as the most important factor is too simplistic and fails to recognise the complexity of surgical outcome, making the same mistake that league tables do.

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1 Carter D. The surgeon as a risk factor. *BMJ* 2003;326:832-3. (19 April.)
2 White C. Surgeons top number of referrals to assessment authority. *BMJ* 2002;325:235.
3 Complaints Resolution. Resolution not retribution. www.hdc.org.nz/complaints/index.html (accessed 23 Apr 2003).

Do patients need to read research?

Cochrane consumer network can help patients

EDITOR—With reference to Smith's question whether patients need to read research,[1] the Cochrane consumer network is a not for profit organisation aimed at helping people to make well informed decisions about health care. It produces summaries of Cochrane reviews in a clear language, avoiding technical words (or providing clear explanation for these words). It has also a section, writen in non-technical language, about the major designs of medical research.

The information is posted at www.cochraneconsumer.com and access is free. Such initiatives can help patients to become better informed to participate in the decisions affecting them.

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1 Smith R. Do patients need to read research? *BMJ* 2003;326:1307. (14 June.)

Knowledge is power

EDITOR—Smith succinctly reminds us of the importance of strengthening capacity among those who need to comprehend research to make informed decisions.[1]

Although his article focuses on patients, I believe we should include all stakeholders in this process of understanding research, be they consumers of health care, clinicians, policymakers, funders, or researchers from other disciplines. Making sense of the massive quantities of information of varying quality is a daunting task even for the skilled researcher. This is further compounded by the confusion brought about when "experts" do not concur on a common interpretation of a given study.

I am a researcher for the Global Health Council, a not for profit organisation with a diverse membership comprised of health-care professionals and organisations that include non-governmental organisations, foundations, corporations, government agencies, and academic institutions that work to ensure global health for all. A key element of our research programme is to promote a better understanding of evidence based approaches to health care and facilitate a dialogue between researchers, policy makers, and practitioners. We do this through web based and paper based resources (including summaries of systematic reviews), workshops, and word of mouth.

As we cannot do this alone, we urge other researchers proactively to initiate dialogue with decision makers, including consumers, about research. Knowledge is power—but it can also be exclusionary if not shared by all who need it.

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1 Smith R. Do patients need to read research? *BMJ* 2003;326:1307. (14 June.)

Reminding patients by text message

Try reverse billing

EDITOR—The use of text messages to remind patients of appointments is truly joined up thinking.[1] To save the NHS money, and to avoid the use of sponsored messages, the system's developers may like to consider reverse billing.

The system is very common. Whether you've voted on *Big Brother* or signed up for text message alerts on your favourite soccer team, you will have come across it. The recipient of any message is billed a few pence on top of standard text charges, collected by their mobile phone network at statement time.

Patients would obviously have to opt in for text messages under the Data Protection Act, so consent for reverse billing could be sought at the same time. Dare I say that this could generate extra revenue for cash strapped primary care trusts?

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1 Dyer O. Patients will be reminded of appointments by text messages. *BMJ* 20034;326:1281. (14 June.)

Why do texts need sponsorship?

EDITOR—Dyer reports that patients will be reminded of appointments by text message and raises the issue of sponsorship.[1] Sponsorship is not sought for clinic appointment letters and other hospital correspondence, so why a 5p text?

In general, alternative means of communication are an excellent idea, which we are exploring in Bath.

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Text reminders could lead to increased health inequalties

EDITOR—Sending text reminders is clearly a good initiative.[1] My concern is that it may increase health inequalities as it applies only to people who can afford to own mobile phones. This means that people in higher socioeconomic groups are less likely to miss appointments and thus are more likely to receive better health care.

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Competing interests: None declared.

1 Dyer O. Patients will be reminded of appointments by text messages. *BMJ* 20034;326:1281. (14 June.)