

ate unique issues for consideration in the development and implementation of decision aids. Developers of screening decision aids need to ensure these issues are adequately addressed.

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Experiences of the *BMJ* ethics committee

Elizabeth Wager on behalf of the *BMJ* ethics committee

The *BMJ* established its ethics committee nearly four years ago. What has it achieved and has it changed the journal's practice?

The *BMJ* ethics committee was established to help editors with difficult cases, to review policies that have ethical implications, and to expand the journal's coverage of ethics.¹ Unlike the Committee on Publication Ethics (which considers anonymised cases submitted by journal editors), the *BMJ*'s committee discusses possible future policies as well as responding to specific issues and sees full details of all cases (although they are anonymised for the minutes, which are available on the *BMJ*'s website (http://bmj.bmjournals.com/advice/bmj_ethics.shtml)).

Since our inception in November 2000 we have met 13 times and discussed 70 cases from the editorial team. Three broad themes have emerged from our discussions. These are:

- Patient confidentiality
- The journal's responsibilities to people outside the publishing process, and
- Research misconduct.

Patient confidentiality

Like many ethical issues, the confidentiality of the doctor-patient relationship sounds straightforward until you are confronted with difficult cases. As part of our review of journal policies with ethical implications, we considered the *BMJ*'s guidelines on publishing information on individual patients. These stated that information should not be published without the patient's consent. That sounds fine, until Minerva wants to publish a picture of an Egyptian mummy^{2,3} or someone submits a piece with an important message describing a patient who died decades ago in a remote part of the world. The committee has therefore revised the guidelines to describe the situations in which publication of individual information without consent might be appropriate.⁴

We also considered whether rules about consent to publish individual data still applied after a patient had

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complained about a doctor to the media. Does the patient's public allegation constitute an implicit consent to have the case discussed? If not, is it fair that the doctor(s) concerned cannot respond to the allegations or attempt to set the record straight? Should the *BMJ* ask patients who write criticisms of doctors to sign a waiver permitting the doctor to respond? Discussions with the General Medical Council and the BMA's ethics committee are still underway, but we hope the outcome will be new recommendations that satisfy natural justice, publication ethics, and the GMC's guidelines (which currently curtail the doctors' right of reply).

Journal's wider duty of care

The committee has considered the journal's responsibilities to people who are not directly involved in the publication process. For example, we discussed a submitted paper that set out unorthodox theories about a serious condition and implied that these formed the basis for the author's clinical practice. This paper did not purport to be a clinical trial, so we could not invoke research ethics committees, but it did raise serious doubts about the author's competence. We recommended that the *BMJ*'s editor should write to the medical authorities in the author's country raising the journal's concerns (so far he has not received a response). Was that a breach of confidence between an editor and an author, or the act of a responsible journal with a duty of care to patients?

We also discussed a letter from junior doctors who had witnessed cheating during their final exams and believed this might have affected their results. This raised an interesting problem: the doctors (now qualified) were to be congratulated for their honesty, but what could the *BMJ* do with the information without harming the authors? The committee felt it would be wrong to contact the medical school without first getting the agreement of the whistleblowers. The editor contacted the authors, and they agreed that he should write to the medical school explaining how this information had been obtained but not revealing its source. The medical school responded that academic staff had, in fact, been aware of the problems at the time and had taken measures to minimise the harm.

Another case involved the journal's duty of care to a patient whose case was reported in a filler article submitted by doctors at a tertiary referral centre. This implied that the patient had been severely disabled because of inadequate care received at another hospital. One reviewer remarked that the patient should sue for negligence: should the journal pass on this advice? We recommended that the authors should be encouraged to pursue the case. However, when the editor sent the reviewer's comments to the authors, it turned out that their report had considerably simplified the case, and, since submission, the patient had made an almost full recovery. These cases taught us an important lesson—that journals usually have only partial information, and it is therefore best to seek clarification from the authors before making any assumptions or taking further action.



Publishing details about a mummy without consent is unlikely to cause problems

ALEXANDER TSIARAS/SPL

Research misconduct

The committee's longest running cases have concerned suspected research malpractice. The individual cases are still under investigation so we cannot report them in detail, but they have raised questions such as whether the editor should inform other journals when a *BMJ* investigation casts serious doubt about papers that they have published and, if so, when? One case has lasted more than four years and shows no signs of resolving. It has involved authorities on several continents and threats of legal action. It might seem fairer to wait until an inquiry has reached a conclusion before alerting other journals, but the committee felt that this would increase the risk that further potentially fraudulent research might be published.

Like many journals, the *BMJ* requires authors to show that research has been approved by appropriate bodies and conducted to relevant ethical standards. In most cases, research ethics committees or institutional review boards approve research proposals, but several grey areas have exercised our committee. For instance, we learnt that there was no provision for ethical review for research conducted in private practice in the United Kingdom. Similarly, it is not always clear how innovative surgical techniques should be studied, and whether variations from standard practice require ethical review and explicit patient consent. We have also discussed reports describing the use of dietary supplements or of licensed drugs at unusual doses that raised concerns about whether patients were fully informed that they were receiving unorthodox treatment.

Perhaps the greyest of areas, and one that the committee has yet to resolve, is the borderline between audit and research. Legislation and guidelines about the use of patient records are in a state of flux,^{5 6} and doctors may not realise that they need to seek approval. We plan to discuss this further at future meetings and to draw up guidelines (or at least point authors in the direction of some helpful resources), since we know readers are concerned about it.⁷

What else has the committee done?

Although much of the committee's work arises from cases referred to us by editors, we have also taken some

Examples of cases discussed

Can the BMJ publish a report by a nurse who had been assaulted by a patient without the patient's consent?
We decided that this case raised an important issue and therefore merited publication but should be published without the author's name or institution, and with only minimal details of the patient, so that the risk of either party being identified was minimised.

If the BMJ has agreed to publish a case anonymously (to avoid identification), can the author also publish a signed commentary of the case as if he were an impartial observer?
We felt that this was deception and therefore unacceptable.

initiatives ourselves, including a review of the *BMJ's* guidelines for contributors. Our aim was to make the guidelines consistent within themselves and with ethics committee decisions and to bring them up to date with other documents such as the latest version of the Declaration of Helsinki. The guidelines now include a section entitled "What we do if we suspect misconduct," so that anyone submitting material to the *BMJ* is aware of what the journal might do in these circumstances.

Review of the guidelines was one of the committee's original objectives.¹ We hope that the new guidelines about publishing patient information, and our discussion of individual cases, have helped editors take difficult decisions and thus fulfilled another objective. However, we have been less successful in increasing coverage of ethical issues in the *BMJ*. As we meet just three times a year, for about three hours, we do not always have time to cover all the items on our agenda. We have given priority to cases referred to us, but, even so, it is sometimes several months before we make a recommendation. This must be frustrating for both authors and editors, and we would like to improve our performance. Another effect of full agendas is that we rarely have time for wide ranging discussions of broader issues and have been less proactive than we might have hoped.

So, what next? We need to do more work on the question of where audit ends and research begins, and

no doubt the *BMJ* editors will continue to provide us with dilemmas to stimulate our discussions. We hope to be more proactive in encouraging coverage of ethical issues in the journal and are currently discussing questions arising from medical genetics. Minutes of meetings will continue to be posted on *bmj.com*, and we also hope to use the rapid response and polling facilities to broaden the debate on important ethical issues and increase readers' involvement. Although we do not claim responsibility for any major changes at the *BMJ*, feedback from the editorial team has been positive, and we feel our work has been helpful. In a busy journal office it can be hard to find time to debate the broad implications of policies or to review policies that need updating. The ethics committee ensures that the *BMJ* editors regularly consider ethical topics, and we hope it has resulted in better, more thoughtful policies for the journal.

The committee currently comprises clinicians with interests in ethical issues arising from brain damage (Derick Wade) and cancer (Jeffrey Tobias), the BMA's head of medical ethics (Ann Sommerville), a former bioethics advisor for the Wellcome Trust (Tom Wilkie), the director of the University of Toronto Centre for Bioethics (Pete Singer), a surgeon from the Agha Khan University in Kenya (Asad Raja), a freelance medical writer (Liz Wager), a consultant anaesthetist and clinical fellow in medical ethics at Imperial College (Andrew Lawson), and a general practitioner (Iona Heath, chair). We thank our previous chair Sandy McCall Smith and former secretaries Alison Tonks, Sandy Goldbeck Wood, and Rachel Fetches for their contribution.

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From head to toe an airborne soldier

As a medical student, I served in a Territorial Airborne unit as an infantry soldier. While on my parachute course, I banged my head on landing and developed a simple headache. At the end of the day's training, back at the RAF base, I reported to the medical reception station and requested some simple analgesia.

I was told that I had to see a doctor first, so I duly requested one. Twenty minutes later an irate doctor appeared and ascertained from the medical orderly that I was a "Para" and had a headache.

Without being given the chance to explain my complaint or background, I was summarily ordered to take off my boots and socks and lie on the bed. A Babinski's reflex test was then looked for. The removal of my footwear had hinted of this possibility, and, thus forewarned, I gave a classic upgoing response.

This result elicited a momentary pause by the doctor, who now addressed me—a thick Para—for the first time and demanded to

know what my symptom was. I stated that I had a headache, adding for good measure that I had dismissed the possible minimal blurred vision, confusion, numb hand, and slurred speech.

Babinski's reflex was then looked for on the other side, again without prior explanation. I therefore gave another upgoing response this time with a bit of withdrawal and toe fanning. We looked at each other, but nothing was said. A prescription for paracetamol was written, and I was ordered to leave.

What did this brief consultation teach me? Speak civilly to your patient, don't assume ignorance, always take a history, don't be arrogant, and don't do a test unless you are going to act on the result—probably the most productive three minutes' teaching in the whole of my medical career.

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