Abstracts of Note: The Bioethics Literature

This section is meant to be a mutual effort. If you find an article you think should be abstracted in this section, do not be bashful—submit it for consideration to feature editor Kenneth V. Iserson care of *CQ*. If you do not like the editorial comments, this will give you an opportunity to respond in the letters section. Your input is desired and anticipated.

Barilan YM. Revisiting the problem of Jewish bioethics: the case of terminal care. *Kennedy Institute of Ethics Journal* 2003;13(2): 141–68.

Varying from the dogmatic Orthodox and ultra-Orthodox medical writers who have long dominated English-language discussions of traditional Jewish medical ethics, this physician-author presents a lucid, balanced, and well-researched perspective on Jewish end-of-life issues. His ability to translate sources into English, without relying on secondary sources, lends authority and completeness to his writings. This article examines the main Jewish sources relevant to end-of-life ethics, including two Talmudic stories, the early modern code of law (*Shulhan Aruch*), and contemporary *Halakhic* responsa (published rabbinical answers to ethical and religious questions). Barilan discusses some Orthodox rabbis' objections to using artificial life support that prolongs the life of a dying patient, as well as the preference of these rabbis for its active discontinuation when the patient is suffering. He contrasts these objections with other rabbis' belief that physicians must take every medical measure to prolong life. He discusses these issues within the context of the "Steinberg Report," a 2002 document of major importance, which proposes a law regulating end-of-life issues in Israel. He argues that Orthodox rabbis base their views on a strongly positivist concept of religious law as a manifestation of God's will, which they try to stretch as much as possible to benefit the patient, even in those instances when the patient's death may be seen as a good thing. The Orthodox prohibition against direct, proactive choices that would result in a patient's death has given rise to proposed bizarre contrivances based on "self-distortion" and "legal acrobatics," such as timers on ventilators, which could simply be allowed to run down if the patient no longer desires mechanical ventilation.

Cleophas GC, Cleophas TJ. Clinical trials in jeopardy. *International Journal of Clinical Pharmacology and Therapeutics* 2003;41(2): 51–5.

These authors, from the Faculty of Law of the Erasmus University, Rotterdam, the Netherlands, warn that controlled clinical trials, the gold standard for clinical research, are in jeopardy. They say that, whereas scientific rigor in clinical trials requires independence and objectivity, the pharmaceutical industry has rapidly expanded its control of this vital research modality. Safeguards to scientific rigor are being compromised, the authors assert, due to the direct benefit industrial sponsors receive from favorable results of and the virtually complete control over these trials. With that orientation, they set out to review procedures that jeopardize the credibility of trials and to look for possible solutions to the conflict between sponsored industry and scientific independence. They found a number of flawed procedures endangering current European clinical trials. Among them are that European pharmaceutical industries are allowed to choose their own independent protocol review boards to approve study designs and human-subject regulation compliance. Also, according to these authors, such independent review boards often approve protocols even when the research is beyond the scope of their expertise. Compounding this problem, trial sponsors ask the health institutions that host multicenter clinical trials not to independently evaluate the studies' scientific merit or ethical soundness. Worse, industry employees often serve as clinical trial monitors, and data control is predominantly in the sponsor's domain. Additionally, researchers rarely have independent groups perform interim data analysis to determine if the studies should be terminated early. The clinical-trial scientific committees consist largely of prominent, but otherwise uninvolved, physicians attached

Cambridge Quarterly of Healthcare Ethics (2004), **13**, 211–213. Printed in the USA.
Copyright © 2004 Cambridge University Press 0963-1801/04 $16.00

https://doi.org/10.1017/S0963180104132167 Published online by Cambridge University Press

to the study who, after briefly reviewing an analysis and report of the trial, which is generally provided by pharmaceutical companies' clinical associates, attach their names to it.

Possible solutions to reduce conflicts between industry sponsorship and scientific independence include surveillance by independent observers during each stage of the trial and reduction of the commercial sponsor's tight control of study data, analysis, and interpretation. The authors suggest that, if the pharmaceutical industry allows the profession to more actively participate in different stages of the trial, scientific research will be better served, reasonable biological questions will be better answered, and the profession will be more convinced of the objective character of the research, thus enhancing sales and better serving the companies' interests.

Patel MV, Pradhan BB, Meals RA. Misrepresentation of research publications among orthopedic surgery fellowship applicants: a comparison with documented misrepresentations in other fields. *Spine* 2003;28(7):632–6.

Sadly, repeated studies have shown that many residency and fellowship applicants to multiple specialties falsify some part of their backgrounds, especially those related to research and publications. However, no prior study looked at orthopedic residents applying for fellowship programs. These authors, from the Department of Orthopedic Surgery at the UCLA School of Medicine, present similar findings for applicants to several types of postresidency orthopedic-surgery subspecialty fellowships (e.g., spine, sports, and hand). Retrospectively reviewing fellowship applications submitted over a 3-year period, these authors assessed the prevalence of research misrepresentation and compared such activity between subspecialties. Competition for orthopedic-surgery fellowships is intense, with the applicant pool including orthopedic, plastic, and general surgeons and neurosurgeons. The authors performed a retrospective analysis of 280 fellowship applications submitted to their institution from 1996 through 1998. They included a minimum 24-month follow-up period to allow for publication delays. Using an exhaustive literature search, they analyzed the applicants' listings of their research publication for evidence of misrepresentation. They only labeled the most obvious and confirmable discrepancies as misrepresentations and then compared their results with those found in similar studies conducted in other fields: gastroenterology fellowship, emergency medicine residency, pediatric residency, dermatology residency, orthopedic residency, and medical faculty applications. Of the 280 applicants for orthopedic surgery fellowships, 151 (54%) claimed journal publications. Of those, 16 (10.6%) had misrepresented their citations, which is, unfortunately, a rate comparable with those reported in other medical fields ($p > 0.1$). They suggest that increased scrutiny of the information on physician applicants' curriculum vitae might lessen this behavior—as might an increased stress on physician professionalism and ethics.

D'Agostino RB Sr, Massaro JM, Sullivan LM. Non-inferiority trials: design concepts and issues—the encounters of academic consultants in statistics. *Statistics in Medicine* 2003;22(2):169–86.

As these authors remind us, placebo-controlled trials are the ideal method for evaluating medical treatment efficacy. This study design controls for the placebo effect most efficiently and requires the smallest number of patients to detect a true treatment result. Researchers can ethically justify a placebo-controlled trial if no standard treatment exists, if the standard treatment has not been proven effective, and if there are no risks associated with delaying treatment or the protocol includes "escape clauses" so that patients can opt out or be removed from the study at any time. Where possible and justified, researchers should use placebo-controlled trials to evaluate medical treatment. However, given the large number of treatments that have been proven effective, placebo-controlled trials are often unethical. In these situations, it is generally appropriate to use active-controlled trials, in which researchers expect both treatment arms to have an effect. When researchers believe that the experimental treatment may be neither clinically and statistically superior nor inferior to a proven effective treatment, an appropriate research design for evaluating the efficacy of an experimental treatment versus an active control is what these authors call a "non-inferiority trial." These trials are not easy to design because they must include a suitable active control that has documented efficacy based on previous well-performed placebo-controlled trials. Study

https://doi.org/10.1017/S0963180104132167 Published online by Cambridge University Press

designers must statistically analyze these historical trials, apply clinical judgment to determine the noninferiority margin, *M*, and evaluate "assay sensitivity." Assay sensitivity establishes that the active drug would be superior to the placebo in the noninferiority trial (constancy assumption). Unfortunately, researchers often do not have usable placebo-controlled historical trials for the active control, and they have difficulty determining assay sensitivity and an appropriate *M*. The authors recommend seriously considering expansions of and alternatives to noninferiority trials.

https://doi.org/10.1017/S0963180104132167 Published online by Cambridge University Press