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.

Pearson SD, Kleinman K, Rusinak D, Levinson W. A trial of disclosing physicians' financial incentives to patients. *Archives of Internal Medicine* 2006;166(6):623–8.

Concern regarding financial conflict of interest for physicians has led to calls for disclosure of financial incentives to patients. However, limited data on the outcomes of disclosure exist to guide policy. The authors conducted a randomized trial among 8000 adult patients at two multispecialty group practices in the Boston, Massachusetts, and Los Angeles, California, areas. Half the patients received a compensation-disclosure letter written by their physician group's chief medical officer, and all patients were surveyed approximately three months later. They found that the patients receiving the disclosure letter were significantly more able to correctly identify their primary care physician's compensation model, in Boston (adjusted *OR*, 2.30; 95% *CI*, 1.92–2.75) and in Los Angeles (adjusted *OR*, 1.37; 95% *CI*, 1.03–1.82). Patients receiving the letter also had more confidence in their ability to judge the possible influence of incentives on their healthcare, in Boston, 32.5% versus 17.8% ($p < .001$) and in Los Angeles, 31.8% versus 26.4% ($p = .20$).

Disclosing the compensation arrangements did not change trust in primary care physicians overall. In fact, of patients who remembered receiving the disclosure, 21.4% in Boston and 24.4% in Los Angeles responded that the disclosure had increased trust either greatly or somewhat, whereas in both cities less than 5% of patients responded that the information decreased trust. Patients' loyalty to their physician group was higher among patients to whom the information had been disclosed, in Boston (73.4% vs. 70.2%; $p = .03$) and in Los Angeles (74.1% vs. 66.9%; where the information had been disclosed, $p = .08$). The authors concluded that among diverse patient populations, a single mailed disclosure letter from physician groups was associated with improved knowledge of physicians' compensation models. Patients' trust in their physicians was unharmed, and their loyalty to their physician group was strengthened. Although the authors hedge their final statement, it seems reasonable that *disclosure to patients should be considered an effective method of enhancing the patient–physician relationship*.

Lee KJ, Havens PL, Sato TT, Hoffman GM, Leuthner SR. Assent for treatment: Clinician knowledge, attitudes, and practice. *Pediatrics* 2006;118(2):723–30.

Rather than simply obtaining parental consent, physicians often ask minors (children) to assent to procedures. The purpose is to help them understand their condition as much as they are able, to tell the child what to expect with the tests or treatment, to assess both their understanding and responses, and to solicit an expression of their willingness to accept the intervention. The American Academy of Pediatrics' (AAP) 1995 policy advocated obtaining assent from minors needing medical interventions; other organizations have supported this idea.

These authors, from the Medical College of Wisconsin, explored clinician knowledge, attitudes, and practice regarding assent for medical treatment and compared current practice with existing AAP guidelines. They administered questionnaires to clinicians who perform procedures on children at an academic tertiary care pediatric hospital to assess their knowledge of and approach to obtaining assent for medical treatment and their familiarity with the AAP policy statement on assent. Of 35 clinicians enrolled, 23 (66%) had heard the term "assent," and 9 (26%) of 35 were aware of the AAP policy statement. Twenty-five (74%) of 34 thought that one

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of the main goals of assent was to educate the child. Only 12 (35%) of 34 included the element of seeking the child's agreement as a goal of assent. In practice, the element of explaining the proposed treatment was "always" included by 26 (74%) of 35. The element of seeking the child's agreement was "always" included by 9 (26%) of 35. The authors concluded that the clinicians in this study had limited explicit knowledge of the concept of assent for medical treatment and were largely unaware of the AAP's recommendations. Their attitudes and practice reflected implicit acceptance of the importance of including children in discussions about their medical care and reluctance to give children decisionmaking authority. *They suggest that a model of medical decisionmaking for children that includes education but does not allow children to share decisionmaking authority may be more applicable to clinical practice than the current AAP-supported model of assent*.

O'Mathuna DP. Human dignity in the Nazi era: Implications for contemporary bioethics. *BMC Medical Ethics* 2006;7(1):E2.

Any discussion of ethics linked to the Nazi era is bound to be controversial, especially when it is used to condemn widely accepted bioethical concepts and policies. This author, from the School of Nursing at Dublin (Ireland) City University, examines social Darwinism, an underlying ethical theory of the Nazi era, and describes the resulting perversion of German medical practitioners' attitudes and practices. She then links this discussion to modern bioethical ideas.

Her fundamental idea is that the justification for Nazi programs involving involuntary euthanasia, forced sterilization, eugenics, and human experimentation was strongly influenced by views about human dignity. In her opinion, the historical development of these views should be examined so that we can avoid similar distortions of human dignity today.

Charles Darwin's evolutionary theory was quickly applied to human beings and social structures throughout the world. According to O'Mathuna, social Darwinism was foremost among the philosophies affecting views of human dignity in the decades leading up to Nazi power in Germany, with social Darwinists rejecting a belief in the inherent dignity of all humans. The term "survival of the fittest," coined in that era and applied to humans, led some authors of the time to proclaim that an individual's worth and value were to be determined functionally and materialistically. The popularity of such views ideologically prepared German doctors and nurses to accept Nazi social policies promoting survival of only the fittest humans.

O'Mathuna believes that five general views of human dignity and ethics derived from social Darwinism strongly impacted medical ethics in the Nazi era: (1) ethical relativism (rather than universal principles); (2) a blurring of the distinctions between humans and animals; (3) race and physical and mental abilities as determinants of human dignity; (4) the belief that some lives have so little value that they are not worth living; and (5) survival of the fittest, which suggests the elimination of those who are not fit.

With what seems to be a political, as well as ethical, agenda, *the author suggests that modern secular bioethicists are in danger of being linked through similar beliefs to Nazi medicine's ideology*: "acceptance of these [values] during the Nazi era proved destructive to many humans. Their widespread acceptance today would similarly lead to much human death and suffering. A different ethic is needed which views human dignity as inherent to all human individuals."

Ball DE, Tisocki K, Herxheimer A. Advertising and disclosure of funding on patient-organisation websites: A cross-sectional survey. *BMC Public Health* 2006;6:201.

The Internet is now a major influence on patients, with many visiting the Web sites of organizations linked to a specific class of illness. These authors, concerned that patient organizations are being exposed to conflicts of interest and undue influence through pharmaceutical industry (Pharma) donations, examined pharmaceutical company advertising and disclosure of financial support on major patient-organization Web sites. Using a defined Google search strategy, they identified 69 national and international patient organizations primarily interested in 10 disease groupings. These organizations were assessed for indicators of transparency, advertising, and disclosure of Pharma funding using an abstraction tool and inspection of annual reports. Data were analyzed by simple tally, with medians calculated for financial data.

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The authors found that patient-organization Web sites were clear about their identity, target audience, and intention, but only a third were clear on how they derived their funds. Only 4 of 69 Web sites stated advertising and conflict of interest policies. Most did not have advertising. More than half the sites (54%) included an annual report, but financial reporting and disclosure of donors varied substantially. Corporate donations were itemized in only 7 of 37 reports and none gave enough information to show the proportion of funding from Pharma. Nearly half (45%) the sponsoring organizations listed Pharma funding on their Web site, but the annual reports named more Pharma donors than did the Web sites (median 6 vs. 1). One-third of the Web sites showed one or more company logos or had links to Pharma Web sites. Pharma companies' introductions were present on 10% of Web sites, with some of them mentioning specific products. Two patient organizations had obvious close ties to Pharma.

The authors concluded that *patient-organization Web sites do not provide enough information for visitors to assess whether a conflict of interest with Pharma exists*. Although advertising of products is generally absent, display of logos and corporate advertisements is relatively common. Display of clear editorial and advertising policies and disclosure of the nature and degree of corporate donations is needed on patient organizations' Web sites. They suggest that if patient organizations are to remain independent and truly represent the interests and views of patients, an ethical code to guide patient organizations and their staff members on how to collaborate with Pharma should be developed and supervised by an independent body rather than through self-regulation.

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