Annals of Internal Medicine

Reviewer: Shalowitz, David

Title: Differences, Disparities, and Biases: Clarifying Racial Variations in Health Care Use

First Author: Rathore, S.

Citation: Annals of Internal Medicine 2004; 141: 635-638

Summary: The authors discuss a conceptual scheme for intepreting data on differential use of health care among racial groups. They suggest that scholarship to this point has not clearly accounted for the source and implications of empirical differences in health care use and propose a three-tiered framework for characterizing these differences.

First, "racial differences" refer to simple empirical reports of varying usage along racial lines.

Second, "racial disparities" refer to differences that persist after accounting for various clinical characteristics (contraindications, patient preferences, patient eligibility, etc.), and that result in poorer clinical outcomes.

Third, "racial bias" refers to racial disparities that cannot be accounted for by various systemic problems (e.g. lack of insurance, access only to poorer-quality providers, etc.) and therefore is likely to be due to provider bias.

This framework seems pretty good, except "racial bias" would be better if bias were somehow established by a positive determination of bias rather than elimination of several alternative causes of the disparity.

Reviewer: Ben Wilfond

Title: Oversight of human participants research: identifying problems to evaluate reform proposals

First Author: Emanuel, Ezekiel

Citation: Annals of Internal Medicine 2004; 141: 283-291

Summary: This paper categorized 15 current problems with IRB into three groups: stuctural problems of the system, procedural problems in the review process, and performance assessment problems. It then discussed how current proposals for IRB reform do not address all the problems. The paper concludes with several recommendations including a permanent advisory committee, singe review of multisite trials, and standardized peformance assessments.

Reviewer: grady

Title: When most doctors are women: what lies ahead

First Author: Levinson W

Citation: Annals of Internal Medicine 2004; 141: 471-474

Summary: Authors predict 4 'notable" changes in medicine as the profession becomes increasingly 'feminized'.
1. Patient-physician relationship is likely to become more patient centered.
2. As effective team leaders that engage and empower others, women will function well in an increasingly multidisciplinary team approach to care at the local level
3. Female physicians are more likely to work in primary care specialities and less well compensated medical positions. They are also more likely to work fewere hours than male physicians.
4. Changes in medical profession: more attention to the balance of work and family; uneven representation in leadership positions, and even the possibility of a decline in the status of the profession.

Reviewer: Ben Wilfond

Title: Physician reports of terminal sedation without hydration or nutrition for patients nearing death in the Netherlands

First Author: ietjens, J

Citation: Annals of Internal Medicine 2004; 141: 178-185

Summary: this paper describes interviews with 410 physician and reports that 211 used terminal sedation(defines as use of drugs to keep patient unresponsive, and not providing nutrition and hydration). The justifications offered included the alleaviation of severe pain (51%), agitation (38%) and dyspnea (38%). Sedation was discussed with patients in 59% of cases and the lack of hydration in 34% of cases. In 17%, the use of terminal sedation was done with an explicit intention to hasten death, and in 47% this was a partial reason.

Euthanisia was discussed with 37% of the patients but the physicians reported that these patients prefered terminal sedation.

Reviewer: Ravitsky

Title: Don't Ask, Don't Tell: The Status of Doctor-Patient Communication About Health Care Costs

First Author: editorial

Citation: Annals of Internal Medicine 2004; 164: 1723-1724

Summary: This editorial relates to an article in the same issue that gives results from a survey of 660 individuals, 35% of which never discussed costs with health care providers. Of 230 patients who did not discuss costs with their doctor, 66% reported that physicians did not ask them about this issue. This is consistent with other studies.

The editorial argues that those who rely on biomedical communication style, rather than the more patient-oriented psychosocial styles, may miss warning signs that patients are having problems. When doctors don't ask and patients don't tell, opportunities to help are missed and patients remain at risk for under-using medications and services because of cost issues that are obstacles in the access to treatment. It is the responsibility of the physician to create an atmosphere in which patients can freely discuss matters that affect their health such as cost.

Reviewer: grady

Title: Clinical trial registration: A statement from the International Committee of Journal Editors

First Author: ICMJE

Citation: Annals of Internal Medicine 2004; 141: 477-478

Summary: Arguing for the value of a clinical trial registry

Reviewer: Ravitsky

Title: Talking with Terminally Ill Patients and Their Caregivers about Death, Dying and Bereavement

First Author: Ezekiel Emanuel

Citation: Annals of Internal Medicine 2004; 164: 1999-2004

Summary: This paper offers data from interviews conducted with 988 patients and 893 caregivers from 6 sites in the US. The goal of the study was to assess whether interviewing terminally ill patients and their caregivers is stressful or helpful, considering the widespread belief that it would be stressful.

The results show that this belief is not empirically grounded. The interviews were rarely perceived as creating stress and were frequently perceived as beneficial (40% of patients perceived some helpfulness and less than 10% experienced stress.)

This data has two important implications: 1. IRBs should not restrict interview-based research unless there are reliable data to indicate that the survey will be stressful. 2. It may be important and helpful to implement structured interviews as part of the routine care of terminally ill patients and their caregivers.

Reviewer: Ravitsky

Title: When Patients Refuse Assessment of Decision-Making Capacity

First Author: Samia Hurst

Citation: Annals of Internal Medicine 2004; 164: 1757-1760

Summary: When patients refuse beneficial treatment, the assessment of decision-making capacity becomes very important. However, sometimes they may refuse to explain their reasons and clinicians may find themselves in difficult situations without ethical guidance.

Samia argues that in such cases, clinicians must first do their best to engage in a dialogue with the patient and try to find others with whom the patient may agree to discuss the reasons for refusal. However, if this attempt is unsuccessful and the risk to the patient is significant - and this is where her argument becomes controversial - clinicians should choose a course of action as if the patient were incompetent, while still explaining that choice to the patient as if he or she were competent.

She explains that her approach neither sacrifices respect for the patient's choices nor care for the patient's best interest. It also allows clinicians to persist in their efforts to establish a conversation with their patients. This paper raises an important question, offers an original approach, and I think the argument is worthwhile.

Bioethics

Reviewer: A Martin

Title: Tailor-made pharmacotherapy: future developments and ethical challenges in the field of pharmacogenomics

First Author: van Delden, JJM

Citation: Bioethics 2004; 18: 303-321

Summary: After reviewing the current state of scientific knowledge regarding how genetic polymorphisms influence drug response, considers some possible future developments in the field and what ethical issues may arise as a result.

Suggests at the end that pharmacogenomic's influence on drug development, the practice of medicine, and society at large may be so enormous as to call for "new ethical research," and that this research will focus on the notion of 'responsibility.' Calling this focus "new" is obviously an overstatement, and it seems what the authors really mean is that it will be important to spell out the specific responsibilities of the various people involved in and affected by pharmacogenomics.

Reviewer: A Martin

Title: Tailored medicine: whom will it fit? The ethics of patient and disease stratification

First Author: Smart A

Citation: Bioethics 2004; 18: 322-343

Summary: Noting that a key selling point of pharmacogenetics is the possibility of targeting treatment to patient sub-groups and sub-types: "personalised medicine," examines the potential for injustice through inappropriate response to the differences defined by pharmacogenetics.

Reviewer: A Martin

Title: Pharmacogenetic testing, informed consent, and the problem of secondary information

First Author: Netzer C

Citation: Bioethics 2004; 18: 344-360

Summary: Objects to the view that pharmacognetic tests are less ethically problematic than other kinds of genotyping by pointing out the range of secondary information that may be contained in pharmacogenetic tests. Additionally argues that pharmacognetic tests may have a large impact on clinical decisions by influences therpeutic strategy and/or patient monitoring. Given these concerns, concludes that there is strong need for quality assurance through regulation of testing, and that we should not be quick to adopt reduced informed consent requirements for pharmacogenetic testing (something suggested by the American Society of Human Genetics in 2000).

Reviewer: A Martin

Title: When hope makes us vulnerable: a discussion of patient-healthcare provider interactions in the context of hope

First Author: Simpson, C

Citation: Bioethics 2004; 18: 428-447

Summary: This is one of the better discussions of hope in the context of healthcare provision. She first lays out a plausible "description" of hope (she shies away from calling it an "analysis" of the concept) as an emotional attitude encompassing a desire for the object of hope, uncertainty as to whether that object can be obtained along with imagining that it can be, and a disposition to act to support the hope. She then elucidates three ways in which hope can make a patient vulnerable--to disappointment if the hope is not realized, to having others reject one's hope, and to a high degree of sensitivity to information that relates to what is hoped for--and sketches recommendations for the healthcare provider in responding to these vulnerabilities.

Reviewer: A Martin

Title: Research ethics committess: differences and moral judgement

First Author: edwards, s.l.

Citation: Bioethics 2004; 18: 408-427

Summary: Presents three arguments against the view that we should strive for complete consistency between research committees. Although some disagreements are bad because they reflect irrationality, carelessness, or the operation of conflicting interests, others should be left or even encouraged.

The three arguments:
1) The "justice" argument: difference of judgment do not necessarily indicate different ethical standards--instead they may reflect differences in cultural preferences.
2) The "moral pluralism" argument: if ethical incommensurability is true, then differences across committees may be legitimate responses to equally balanced but incommensurable goods.
3) The "due process" argument: I didn't really get this argument on a quick read-through. It's something like this: even if we agree on a decision-making process, substantive disagreements will always lead to differing conclusions (and I guess these substantive disagreements are assumed to be legit, maybe on the basis of the moral pluralism argument); furthermore, we can't agree on a single decision-making process. (Again, this "can't" must be morally loaded, I guess.)

Reviewer: A Martin

Title: Ethical implications of pharmacogenetics--do slippery slope arguments matter?

First Author: Schubert L

Citation: Bioethics 2004; 18: 361-378

Summary: Nice analysis of the various kinds of slippery slope argument (conceptual/empirical, positive/negative), and of the criteria for the evalution of slippery slope arguments.

Reviews a number of popular slippery slope arguments specific to pharmacogenetics, and concludes that though they satisfy some criteria, they are ultimately "of limited power." Maintains, however, that, as metaphors, these arguments may be useful for highlighting the ethically promising and problematic aspects of pharmacogenetics.

British Medical Journal

Reviewer: grady

Title: Humanitarian medicine: up the garden path and down the slippery slope

First Author: Harding-Pick, Debra

Citation: British Medical Journal 2004; 329: 398-399

Summary: Political action to control migration to richer countries makes asylum seekers vulnerable

Doctors working with asylum seekers may find tension between professional values and the policies of their employers

Stronger guidelines are needed on human rights and ethical issues

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Reviewer: grady

Title: Can the millennium development goals be attained?

First Author: Haines, Andy

Citation: British Medical Journal 2004; 329: 394-397

Summary: Reviews the reason for and progress towards acheiveing the eight millennium development goals proposed in 2000 that represent commitments to reduce poverty and hunger, to tackle ill health, gender inequality, lack of education, lack of access to clean water, and environmental degradation. The goals are a means fior holding to account those responsible for providing health services and help define the role of health in development. 3 of 8 goals and many of the indicators relate to health. The goals provide a focus for development efforts and a lens through which to assess government plans, budgets, and poverty reduction strategies, and they demonstrate the need for urgent action by showing how far progress lags behind expectations. "If global progress continues at the same pace as in the 1990s, only the millennium development goals of halving poverty and halving the proportion of people without access to safe water stand a realistic chance of being met, thanks mainly to China and India. Sub-Saharan Africa would not reach the poverty goals until the year 2147 and for child mortality until 2165." Achieving the health millennium development goals is one of the greatest challenges in international development, not least because they include the goal of reversing the global epidemic of HIV/AIDS. Added to this are the steep declines required in child and maternal mortality, where progress lags far behind aspirations in many parts of the world. Improving health outcomes will not be possible without major improvements in healthcare delivery systems, which in turn depend on changes in public sector management, new forms of engagement with the private sector (leading, for example, to wider availability of affordable drugs, vaccines, and diagnostics), more research directed at improving health systems, as well as policies and interventions well beyond the health sector itself. Improvements in health are essential if progress is to be made with the other millennium development goals, including the reduction of absolute poverty.

Reviewer: grady

Title: National questionnaire survey on what influences doctors' decisions about admission to intensive care

First Author: Escher, M

Citation: British Medical Journal 2004; 329: 425-426

Summary: Study sought to determine what influences doctors' decisions about admission of patients to intensive care.
National questionnaire survey in Switzerland using eight clinical vignettes involving hypothetical patients.
402 Swiss doctors specialising in intensive care responded by rating factors influencing decisions on admission and response to eight hypothetical clinical scenarios.
232 doctors (61%) returned questionnaires. Most rated as important or very important the prognosis of the underlying disease (82%) and of the acute illness (81%) and the patients' wishes (71%). Few considered important the socioeconomic circumstances of the patient (2%), religious beliefs (3%), and emotional state (6%). In the vignettes, underlying disease (cancer versus non-cancerous disease) was not associated with admission to intensive care, but four other factors were: patients' wishes (odds ratio 3.0, 95% confidence interval 2.0 to 4.6), "upbeat" personality (2.9, 1.9 to 4.4), younger age (1.5, 1.1 to 2.2), and a greater number of beds available in intensive care (1.8, 1.2 to 2.5).
Conclusions Doctors' decisions to admit patients to intensive care are influenced by patients' wishes and ethically problematic non-medical factors such as a patient's personality or availability of beds. Patients with cancer are not discriminated against.

Reviewer: 2004

Title: Questionaire survey on use of Placebo

First Author: Nitzan, U

Citation: British Medical Journal 2004; 329: 944-946

Summary: This was a survy of 89 clinicians in two hosptials in Jerusalem about their use of placebos in clinical practice. 60% used placebos. 68% of these told patients they were receiveing an active medication. Only 4% told the patients that they were receiving a placebo.

Reviewer: Ben Wilfond

Title: What has evidence medicine done for us

First Author: Straus, S

Citation: British Medical Journal 2004; 329: 987-988

Summary: This issue of the BMJ is on the theme of evidence based medicine, and the challenges and limitations of its use.

Reviewer: Ben Wilfond

Title: Informed consent and communication of risk from radiological and nuclear medicine examinations

First Author: Picano, E

Citation: British Medical Journal 2004; 329: 849-851

Summary: This paper discusses the challenges of risk communication for administration of radation. The author describes three standard approaches: 1) not discussion, 2) understatement, (it is safe) and 3) full disclosure (ie the NIH RSC statements).

The authors discuss various options to try to make the notion of risk understandable, including comparing it ordinary life (smoking and cars), or compared to CXRs. The authors suggest a graphic protrayal of procedrues and cancer risk. The value of this approach would need to be emperially asssessed.

Reviewer: Ben Wilfond

Title: Making decisions when the states are high and the evidence unclear

First Author: Hu, w

Citation: British Medical Journal 2004; 329: 852--854

Summary: The is a case analysis of different approach to the risk on anaphylaxis after a mild reaction and when it is it necessary to recommend the use of an epi pen.The case shows two different secarios where parents interpet risk differently and have diffent aprpaoches are used. The case also decribes variing approaches to removing peanuts from the childs envonment (banning peanuts to all children in the same school).

The duscussion focuses the lack of evidence of risk, the cost of autoinjectors, parental preferences, risks of hypervigillence, and the importance of special efforts to protect children from risks. The authors conclude, that in the face of uncertainly, there is room variable approaches

Hastings Center Report

Reviewer: Ravitsky

Title: Pharma Goes to the Laundry

First Author: Carl Elliott

Citation: Hastings Center Report 2004; 34: 18-23

Summary: Carl Elliott's essay is fascinating and extremely disquieting. He analyzes and exemplifies how Pharma launders money using academia in order to promote its own agenda. After reading this you seriously wonder how stupid one can be and still be a distinguished researcher.

Elliott describes the following facts:
- Pharma now funds over 60 percent of continuing medical education in the US.
- The communication of results regarding new drugs is often done by pharma using ghost writers to write articles reporting the results, and then paying academics to sign their names on the papers.
- A survey on articles regarding Zoloft published between 1998 and 2000, showed that the ghost-written agency-prepared articles outnumbered the traditionally-written articles, they were published in more prestigious journals, their citation rate was over five times higher and they painted a happier profile of Zoloft.
- The AMA campaign to educate doctors on the ethics of industry gifts was funded by pharma.

And much more.

His argument is simple: Individually, pharma influence may indeed be slight, but we must acknowledge that even though we cannot see a provable causal link between funding and individual behavior, real influence can still be exerted in the general structure and it represents an enormous betrayal of public trust.

He further argues that disclosure as a remedy for conflict of interests is an utter failure and calls it an "empty ritual to ease the consciences of academics unable to wean themselves from the industry payroll". He asks why change is hard to bring about and gives the obvious answer: it is in nobody's financial interest. Moreover, the harm is so diffused that each individual feels like it is not their responsibility. He offers a solution: go read..

Reviewer: Lie, Reidar K.

Title: Extreme prematurity and parental rights after Baby Doe

First Author: Robertson, John A.

Citation: Hastings Center Report 2004; 34: 32-39

Summary: The article discusses the evolving standards of treating newborns with defects or estremely premature infants. With the decision in Miller v. HCA, parents were given greater discretion in making these decisions. Robertson argues that this new standard deviates from the principle that all persons who are conscious and not imminently dying should have equal access to medical services. He the discusses a position that would say that "treatment is required only if the child possesses some threhold level of cognitive ability", and the difficulties in determining what this threshold should be. He then discusses a procedural approach which he apparently favors, specifying where the burden of proof should be. "Under the approach suggested here, neither the parents nor the physicians would be liable if the parents made a good-faith judgment that treatment would not servie the child's interests and the physicians and hospital respected that choice. However, caregivers should also be free to challenge the parents' decision because of a good-faith belief that the child would possess the capacity for symbolic interaction". I find this quotation puzzling.

Reviewer: Lie, Reidar K.

Title: Genetic research & communal narratives

First Author: Davis, Dena S.

Citation: Hastings Center Report 2004; 34: 40-49

Summary: The author argues that genetic research also carries risk for communities, not only individuals. She uses two example, the genetic identify of the lemba, a black South African tribe with a Jewish cultural identity, where genetic tests confirmed their semitic origin. The other example is the relationship between Thomas Jefferson and his slave, Sally Hemings. In both examples, according to Danis, the genetic tests has the possibility of questioning deeply held cultural beliefs of who one is. There is, however very little additional analysis of what follows from this in the article.

Reviewer: Ravitsky

Title: The Bioethics of Business: Rethinking the Relationship between Bioethics Consultants and Corporate Clients

First Author: Raymond De Vries

Citation: Hastings Center Report 2004; 5: 28-32

Summary: Paid bioethicists are not inclined to bite the hand that feeds them. Having an “ethics advisory board” is an excellent PR move from the point of view of the corporation and so there is a great temptation for bioethicists to get on the payroll as well. However, bioethics consultants, unlike other consultants, want the company to do good, rather than do well. Public credibility rests on the perception that bioethics advice is free from corporate influence. If this credibility is questioned, some may start to question the relevance of bioethics to research.

The writers propose the creation of a “consortium for bioethics consulting” funded by a combination of corporate and government money. Corporations in need of bioethical consultation will issue a request to a review committee. This will set a standard against which private consults can be judged.

Reviewer: Ravitsky

Title: Piercing the Veil of Corporate Secrecy about Cilnical Trials

First Author: Trudo lemmens

Citation: Hastings Center Report 2004; 34: 14-18

Summary: Ever more of those involved in research now have financial relationships with the industry and these relationships have become more cozy and friendly. “When commercial sponsors design the protocol, interpret the results, control publication of the outcome, fund advocacy (…) and spend millions on commercial campaigns to promote a new drug, there is reason to worry about whether the process is generating reliable data.” He advocates regulations obliging the conduct of independent comparative studies and clear policies about the openness of clinical trial results.

He supports the novel approach suggested by Sheldon Krimsky to establish an independent national institute for drug testing. Bottom line: we must develop a more independent, tightly regulated review sector and reinvigorate traditional university values in order to restore confidence in the integrity of medical research.

Reviewer: Lie, Reidar K

Title: The contribution of demoralization to end of life decisionmaking

First Author: Kissane, David W

Citation: Hastings Center Report 2004; 34: 21-31

Summary: The author argues that there is "a demoralization syndrome" characterized by "morbid existential distress". He argues that it is a distinct syndrome, different from depression. There are some muddled arguments about how to define disease before he reaches that conclusion. Since people who suffer from this syndrome are not able to make autonomous decisions, it follows that they cannot make valid decisions about physician assisted suicide.

Health Affairs

Reviewer: Lie, Reidar K.

Title: Is 'moral hazard' inefficient'. The policy implications of new theory

First Author: Nyman, John A.

Citation: Health Affairs 2004; 23: 194-199

Summary: This paper takes up the problem of 'moral hazard' in health insurance purchases. The standard account is that people who are insured, will use more health services that they would if they had to pay for the health care themselves, thus creating inefficiency in the use of resources. Nyman argues that this argument, first generally intoduced by Mark Pauly, strictly speaking only holds for health care such as routine visits, not for life-saving care, such as cancer surgery. He argues that if people were given cash payments when ill, and decided to buy additional care with those payments, there is no welfare loss. Traditionally, cost sharing (copayments etc) have been used to deal with moral hazard, but the author suggests that this is a mistake. Two other implications are that health insurance should be subsidized and that high health care prices are not necessarily good

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Reviewer: Reidar Lie

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Reviewer: Lie, Reidar K.

Title: Intergenerational equity and public spending

First Author: Newacheck, Paul W and Benjamin, AE

Citation: Health Affairs 2004; 23: 142-146

Summary: This issue of Health Affairs contains a number of articles on child health, including issues of equity. I have just selected one of them, with a more (in a relative sense) conceptual argument. The authors point out that the conventional analysis is that generations fight for scarce medical resources, and that older people have generally been favored over children. The absolute share of resources going to children is smaller, and the gap is increasing. The author argues that one should adopt a needs based approach to health care rather than an entitlement approach.

Health Economics

Reviewer: Sabik, Lindsay

Title: Do economic cycles have a permanent effect on population health? Revisiting the Brenner hypothesis

First Author: Laporte, Audrey

Citation: Health Economics 2004; 13: 767-779

Summary: This paper examines the hypothesis that economic cylces (based on unemplyoment and fluctuations in per capita GDP) have negative implications for public health. The findings here suggest that economic cycles do have a permanent effect on population health. They also suggest that both economic growth and increased unemployment reduce aggregate mortality risk.

Reviewer: Frank L

Title: A Longitudinal Analysis of Mental Health Mobility in Britain

First Author: Hauck, K

Citation: Health Economics 2004; 13: 981-1001

Summary: Cross-sectional data on mental health may overstate inequality, if there is significant mental-health mobility. The authors of this paper develop a method for measuring longitudinal mental-health mobility. Generally, they find substantial mental health mobility. Although non-whites generally have lower mental health, they also have greater mobility. Persons with lower incomes also have lower mental health, and they also have lower mobility.

Reviewer: Frank L

Title: The Effect of Work on Mental Health: Does Occupation Matter?

First Author: Llena-Nozal, A

Citation: Health Economics 2004; 13: 1045-1062

Summary: This article discusses the impact of choices concerning work and occupation on mental health. The authors analyze longitudinal data from the National Child Development Survey, which follows a cohort of children born in 1958 in the UK over four decades. Among their various findings: mental health worsens with age, but that working slows down this deterioration; and that for women, quality of work is more important than for men in slowing down this deterioration.

Reviewer: Frank L

Title: Measurement and Explanation of Socioeconomic Inequality in Health with Longitudinal Data

First Author: Jones, A. M

Citation: Health Economics 2004; 13: 1015-1030

Summary: This article presents a method for measuring income-related health inequalities based on longitudinal data. The authors argue that cross-sectional data may underestimate the degree of inequality, because healthy individuals may be upwardly income mobile, while unhealthy individuals may be downwardly income mobile. If so, averaging over longer and longer periods of times will reveal greater and greater inequality. The authors develop their model formally, and then apply it to nine years of data from the British Household Panel Survey.

IRB

Reviewer: John Barton

Title: Quebec Physicians' Knowledge and Opinions Regarding Substitute Consent for Decisionally Incapicitated Older Adults

First Author: Bravo G et al

Citation: IRB 2004; 26: 12-17

Summary: This is a report of a survey of physicians regarding their knowledge of substitute consent procedures for decisionally incapicated older adults. This is an issue heavily affected by Quebec legislation. The survey, which supplements an earlier survey of older adults, caregivers, researchers, and ethics review boards, found that the physicians made substantial errors in their (up to 67 % mistaken) on who could give assent for participation in research.

Reviewer: John Barton

Title: Correction

First Author: Appelbaum et al

Citation: IRB 2004; 26: 18-18

Summary: This is an important correction to a study of therapeutica misconception published in the March-April issue. The columns of a key table were reversed.

Reviewer: John Barton

Title: Commercial Tissue Repositories: HIPAA Raises Sponsors' Fears

First Author: Allen, Michael D

Citation: IRB 2004; 26: 9-11

Summary: A review of the legal problems of obtaining the necessary consent under HIPAA for transferring subject's tissues to commercial repositories. Because the statute prohibits exculpatory language, statements of intention of the sponsor or explicit opt-out procedures are suggested.

Reviewer: John Barton

Title: Quebec Physicians' Knowledge and Opinions Regarding Substitute Consent for Decisionally Incapacitated Older Adults

First Author: Bravo G et al

Citation: IRB 2004; 26: 12-17

Summary: This is a survey of physicians regarding their knowledge of who can give consent for treatment and studies of decisionally incapacitated older adults, an issue governed by statute in Quebec. The survey, which supplements an earlier study of older adults, caregivers, researchers, and ethics review boards, finds that physicians are not well informed on the research standards, with as many as 67.6 % giving incorrect answers in some cases.

Reviewer: John Barton

Title: Commercial Tissue Repositories: HIPAA Raises Sponsors' Fears

First Author: Allen, Michael D

Citation: IRB 2004; 26: 9-11

Summary: A short review of the legal problems of informed consent under HIPAA for transfer of subject's tissues to commercial repositories. Exculpatory language is prohibited, meaning that language of intention or opting out systems are necessary if a researcher wishes to send specimen to a commercial repository

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JAMA

Reviewer: Hampson

Title: Full-Body CT Scans Scale Up Cancer Risk

First Author: Hampton, Tracy

Citation: JAMA 2004; 292: 0-0

Summary: For those of you interested in assessing risks…
CT corresponds to dose comparable with a level of radiation that has been associated with increased cancer mortality (Hiroshima, Nagasaki atomic bomb survivors). Undergoing a SINGLE full-body CT scan at age 45 would confer an estimated risk of 0.08% of developing a fatal radiation-induced cancer. For those undergoing an ANNUAL full-body CT scan from age 45-75, estimated risk is 1.9%. Must weigh these risks when thinking about CTs. From Brenner et al.'s article (2004;232:735-738).

Reviewer: Hampson

Title: 150th Anniversary of John Snow and the Pump Handle

First Author: MMWR

Citation: JAMA 2004; 292: 1950-1950

Summary: Epidemiology got its start 150 years ago when John Snow observed that the people that were dying from cholera in London lived near the Broad Street pump. Snow had community leaders remove the pump handle and the incidence of cholera decreased, supporting Snow's theory that cholera was a waterborne, contagious disease.

Reviewer: Hull, Sara
Title: Addressing the Ethical, Legal, and Social Issues Raised by Voting by Persons with Dementia
First Author: JH Karlawish
Citation: JAMA 2004; 292: 1345-1350
Summary:

Reviewer: Hampson
Title: Interventions to Improve Research Participants' Understanding in Informed Consent for Research
First Author: Flory, James
Citation: JAMA 2004; 292: 1593-1601
Summary: James' and Zeke's article on interventions targeted to improve informed consent:
-multimedia interventions (3/12 showed significant improvements in understanding)
-enhanced consent forms (6/12 showed significant improvement but 5 of them were of questionable quality)
-extended discussion (3/5 showed significant improvement and 2/5 showed trends towards improvement)
-test/feedback (5/5 showed significant improvement but all were flawed).
Their recommendations: Only limited success with multimedia (which can be really expensive) and enhanced consent forms, probably more effective to concentrate on talking with research participants individually.

Reviewer: Hull, Sara
Title: The "Duty to Warn" a Patient's Family Members about Hereditary Disease Risks
First Author: K Offit
Citation: JAMA 2004; 292: 1469-1473
Summary:

Reviewer: Hull, Sara
Title: Consumer-Driven Health Care: Lessons from Switzerland
First Author: RE Herzlinger
Citation: JAMA 2004; 292: 1213-1220
Summary:

Journal of General Internal Medicine

Reviewer: Hull, Sara
Title: Will Insured Citizens Give Up Benefit Coverage to Include the Uninsured
First Author: SD Goold
Citation: Journal of General Internal Medicine 2004; 19: 868-874
Summary:

Reviewer: Wendler
Title: Altruism and Coverage of the Uninsured
First Author: Sessums LL
Citation: Journal of General Internal Medicine 2004; 19: 896-896
Summary: Editorial praising Marion's paper and arguing that it reveals an underappreciated sense of altruism that might tapped to provide coverage for the insured.7

Reviewer: Wendler
Title: Will Insured Citizens Give Up Benefit Coverage to Include the Uninsured?
First Author: Marion and colleagues
Citation: Journal of General Internal Medicine 2004; 19: 868-874
Summary: Nice study by Marion and colleagues using the CHAT methodology to show that Minnesotans are willing to allocate 2%-4% of their health insurance premium to cover the uninsured.

All 29 groups chose to insure children; 22 of 29 groups also chose to insure adults. More individuals chose to cover the uninsured at the end of the group deliberation than before (66% vs 54%).

Reviewer: Wendler
Title: When Is Medical Treatment Futile?. A Guide for Students, Residents, and Physicians
First Author: Kasman DL
Citation: Journal of General Internal Medicine 2004; 19: 1057-1063
Summary: The author argues, as others have before her, that futility is an assessment relative to a particular goal (e.g. keeping the patient alive versus returning the patient to her prior state of health). She argues that physicians should discuss and attempt to find consensus with patients and families regarding cases involving potential futility.

Reviewer: Wendler
Title: Barriers to Excellent End-of-life Care for Patients with Dementia
First Author: Greg A. Sachs, Joseph W. Shega, Deon Cox-Hayley
Citation: Journal of General Internal Medicine 2004; 19: 1057-1063
Summary: The authors argue that too often end of life medical care for patients with dementia is characterized by overly aggressive treatments, and and insufficient pain control.

The authors identify several barriers to quality end-of-life care for patients with dementia, including dementia not being viewed as a terminal illness; the nature of the course and treatment decisions in advanced dementia; assessment and management of symptoms; the caregiver experience and bereavement; and health systems issues. They then offer several approaches to overcoming these barriers.

Reviewer: Hull, Sara
Title: Promoting Advance Directives Among Elderly Primary Care Patients
First Author: LS Wissow
Citation: Journal of General Internal Medicine 2004; 19: 944-951
Summary:

Reviewer: Hull, Sara
Title: What do Phsycians Tell Patients about Themselves? A Qualitative Analysis of Physician Self-Disclosure
First Author: MC Beach
Citation: Journal of General Internal Medicine 2004; 19: 911-916
Summary:

Reviewer: Hull, Sara
Title: Is Physician Self-Disclosure Related to Patient Evaluation of Office Visits?
First Author: MC Beach
Citation: Journal of General Internal Medicine 2004; 19: 905-910
Summary:

Reviewer: Wendler
Title: Barrier to Patient-physician communication about out of pocket costs
First Author: Alexander CG et al
Citation: Journal of General Internal Medicine 2004; 19: 856-860
Summary: Authors assessed barriers to discussion of out of pocket costs. Findings are that 11% of patients and 20% of physicians could recall a time when they wanted to discuss this issue, but didn't.

Among patients, the barriers included their own discomfort (19%), insufficient time (13%), a belief that their physician did not have a viable solution (11%), and concerns about the impact of discussions on quality of care (9%). Among physicians, the most common barriers were insufficient time (67%) and a belief that they did not have a solution to offer (19%).

Journal of Law, Medicine and Ethics

Reviewer: Litton, Paul

Title: Conserving Scarce Resources: Willingness of Health Insurance Enrollees to Choose Cheaper Options

First Author: S. Hurst, J.R. Teagarden, E. Garrett, E. Emanuel

Citation: Journal of Law, Medicine and Ethics 2004; 32: 496-499

Summary: Report of a survey to evaluate the willingness of enrollees in pharmacy benefit plans to forgo non-essential benefits – like the convenience of taking one pill per day instead of four – by accepting a generic drug instead of the more expensive brand name drug. The authors found that a majority of people were willing to forgo the non-essential benefits only when a lower co-payment accompanied the generic drug. “Individuals who believed that the pharmacy benefit plan had limited resources, that other plan members were using less expensive options when available, and that the saved money would go to reduced premiums or increased benefits, were more willing to use clinically equivalent generic drugs. Yet most respondents did not espouse these views.”

Reviewer: Litton, Paul

Title: "Underground Euthanasia" and the Harm Minimization Debate

First Author: Magnusson, Roger

Citation: Journal of Law, Medicine and Ethics 2004; 32: 486-495

Summary: After recounting both the prevalence and tragedies of illicit underground physician-assisted suicide (PAS) and active voluntary euthanasia (AVE) (tragedies include botched attempts, lack of psychological assessments), the author undertakes a consequentialist analysis to compare the harms of our current system with one in which those practices are regulated by law. Specifically, he makes the following arguments: 1) lack of foolproof safeguards is not determinative of the matter; 2) the law must not be overly bureaucratic or else doctors will ignore them; 3) legalizing euthanasia or PAS may bring calls for improved palliative care as an alternative; 4) many people, even if they don’t opt for PAS, are comforted by knowing its an option; 5) slippery slope arguments used by opponents fail to acknowledge the harms already occurring in the current system; 6) the symbolism of illegal euthanasia (our “culture of life”) also leads to a culture of deception, because doctors fudge records, etc., to make PAS or AVE look justified. The author suggests that empirical studies would help compare the harms under our regime and one in which PAS and AVE are legal, and that views about the inherent moral acceptability of those practices should not influence the data.

Reviewer: Litton, Paul

Title: Health of the People: The Highest Law?

First Author: Lawrence Gostin

Citation: Journal of Law, Medicine and Ethics 2004; 32: 509-515

Summary: Gostin argues that the field of public health law and ethics needs a definition, an articulated vision, and a strategy to promote public health. He argues that government has a special responsibility to serve the health needs of populations, and that while we recognize individual freedom as important, we must "recapture a classic republican tradition that [also] emphasizes communal obligations." Public health should be a salient public value because health is a foundation for personal well-being and the exercise of individual rights, and because governments are formed primarily for the health safety and welfare of their people. Gostin advocates certain measures to help communities use law as a tool to promote health. For example, he suggests the government tax and spend to create incentive for healthy activities and reduce risky behavior (tax relief for child care and charitable contributions, and tax burdens for cigarettes, alcohol, etc); initiate a public health educational campaign; reduce economic disparities to improve morbidity and mortality; pursue tort litigation to innovate for safety; and to create a new public health ethic that values public health and reflects a renewed commitment to the ideals of community and partnership.

Reviewer: Litton, Paul

Title: Litigation in Clinical Research: Malpractice Doctrines Versus Research Realities

First Author: E. Haavi Morreim

Citation: Journal of Law, Medicine and Ethics 2004; 32: 474-484

Summary: Morreim argues that in order for courts to take a jurisprudentially sound approach to injuries and injustices caused in the research setting, they need to have a clear understanding of how research is different from medical care. Standard medical tort doctrines must be modified to accommodate the different characteristics of research. For example, in negligent cases, plaintiffs must prove that the defendant owed a duty to her, breached the duty, and that the breach caused harm. In research the duties that investigators owe their subjects are different than the duties that physician-care-givers owe their patients, and courts must understand that. In addition, while some courts have attributed fiduciary duties to medical care providers or have allowed breach-of-fiduciary-duty actions to proceed against them, researchers are not fiduciaries to their subjects and therefore should not be subject to such causes of action (except insofar as they also act within the standard doctor-patient relationship). Furthermore, Morreim argues that even though battery has a very limited role to play in traditional medical malpractice cases, there should be a distinctive "medical research battery" as a cognizable cause of action for patients subjected to research without knowledge or consent, even if they have consented to the intervention at issue. The informed consent doctrine should also be tailored to the specific characteristics of research: for example, a distinctive standard of disclosure is necessary, which would require telling patients clearly that their study is not geared towards their individual benefit.

Reviewer: Litton, Paul

Title: Governing the Globalization of Public Health

First Author: Allyn Taylor

Citation: Journal of Law, Medicine and Ethics 2004; 32: 500-508

Summary: This article discusses the rising need for new global health governance. The author is concerned because the patchwork development of international law in this field is creating the risk of inconsistent and suboptimal law. He argues that centralized management and coordination is needed, especially because international health law cannot be formulated in isolation; its issues are inseparable from international environmental law, trade law, human rights law, etc. The article calls on the WHO to take the lead role in rationalizing the international health law enterprise, despite its limited experience with law making and coordination. Based on the scholarship in international environmental law, the author makes recommendations to WHO leadership: to promote global dialogue and set an agenta; to monitor and participate in increasing array of treaty efforts; and to serve as a platform for codifying and implementing international legal agreements.

Kennedy Institute of Ethics Journal

Reviewer: Lovett, Frank

Title: The Dead Donor Rule: Lessons from Linguistics

First Author: Shewmon, D A

Citation: Kennedy Institute of Ethics Journal 2004; 14: 277-300

Summary: This paper elaborates on ambiguities with respect to the concept of death, and argues that the DDR has focused on the wrong ethical question.

The concept of death was developed when medical technology and knowledge did not require finer distinctions. We are now aware of a wide variety of different events that might or might not qualify for that label. The relevant question is not whether a person is dead or not (as DDR suggests), but rather under which of these possible scenarios ‘ death behavior’, including for example organ procurement, is ethically warranted.

One way to formulate question is, When can organ X be removed without causing or hastening death? For example, once blood flow has stopped, removing the hart causes no harm, whether or not some arbitrary definition of death has been satisfied.

Reviewer: A Martin

Title: The Ohio Study in Light of National Data and Clinical Experience

First Author: Schmidt T

Citation: Kennedy Institute of Ethics Journal 2004; 14: 235-240

Summary: Finds Siminoff et al study re: public beliefs about dead donor rule "strikingly consistent" with both a national study conducted by author (published 2003) and the author's clinical experience. Main points of agreement:

>widespread confusion re: the understanding of "brain death"
>majority unwilling to violate dead donor rule
>but significant minority willing to violate it

Recommends slow move toward clinically-defined exceptions to dead donor rule, and change in state statutes.

Reviewer: A Martin

Title: Polling and Public Policy

First Author: Hausman D

Citation: Kennedy Institute of Ethics Journal 2004; 14: 241-247

Summary: Surveys five possible answers to the questions:
1) Why ask people what they think death is and when they think it is permissible to harvest organs?
2) What can we learn from their answers?

Cautions that the results of the Siminoff et al study re: public beliefs about dead donor rule should not influence policy, because it establishes at most what current public preferences are, and did not elicit answers about how these preferences might change in light of new information (e.g. new info re: criteria for brain death).

Reviewer: A Martin

Title: Reconsidering the Dead Donor Rule: Is it Important That Organ Donors Be Dead?

First Author: Fost N

Citation: Kennedy Institute of Ethics Journal 2004; 14: 249-260

Summary: Criticizes the dead donor rule on the grounds that it oversimplifies general practice and is not consistent with widely shared views of ethically acceptable interventions on incompetent and dying patients. States that a great deal of support for dd rule has been drawn from putative fact that public was opposed to its violation. Sees Siminoff et al study as revealing that it may be time for policy change re: procurement of organs.

Reviewer: Lovett, Frank

Title: The Dead Donor Rule: How Much Does the Public Care … And How Much Should We Care?

First Author: Crowley-Matoka, M

Citation: Kennedy Institute of Ethics Journal 2004; 14: 319-332

Summary: Various arguments have been advanced with the goal of increasing the organ donor pool, but concern regarding possible public backlash remains. (In Denmark, public debate over the 'brain death' concept is partly blamed for a 50 percent decline in donation rates.) Thus the Ohio study by Siminoff, et al., provides useful information, but it should be interpreted with caution. The best that can be said is that the DDR is not an absolutely clear standard, and that this is reflected in the confusion of laypersons.

This article wonders why so much energy in the bioethics community has been spent debating the DDR, and so little on universal health care or infant mortality. The authors feel that rather than serving as a watchdog or critic of the existing medical system, the pressures of funding, publication, and so on have driven bioethicists to 'go native' and absorb the general values of that system as they are.

Reviewer: Lovett, Frank

Title: Harvesting the Living?: Separating Brain Death and Organ Transplantation

First Author: Campbell, C S

Citation: Kennedy Institute of Ethics Journal 2004; 14: 301-318

Summary: Campbell is skeptical of the value of public opinion data in resolving the organ scarcity problem. This is because it is not clear what the appropriate response to difference of opinions is, because the opinions reported might not correspond with actual behavior, and so on.

Both revising our conception of death, or creating exceptions to the DDR, would involve violating important social values. Rather, bioethicists should reconsider the priority of organ transplantation in health care. Assuming continued technological advances, there is no reason to think that any policy change could ever solve the problem of organ scarcity. Campbell worries that the pressure of scarcity might distort our moral reasoning in thinking about the meaning of death.

Reviewer: A Martin

Title: Deatha and Organ Procurement: Public Beliefs and Attitudes

First Author: Siminoff L

Citation: Kennedy Institute of Ethics Journal 2004; 14: 211-234

Summary: This entire issue is dedicated to the issue of the dead donor rule. The first article presents the findings from a recent study done by Siminoff, Burant, and Younger (to appear in Social Science and Medicine). The eight articles present competing interpretations of these findings.

The Siminoff et al study was a telephone survey of 1351 Ohio residents. Most respondents were not willing to vioate the dead donor rule, but neither did most of them understand the current definitions of "brain death."

Reviewer: Lovett, Frank

Title: Abandon the Dead Donor Rule of Change the Definition of Death?

First Author: Veatch, R M

Citation: Kennedy Institute of Ethics Journal 2004; 14: 261-276

Summary: This article disputes the interpretation of the Ohio study offered by Siminoff et al. Rather than suggesting that people might be willing to violate the DDR, it is possible that people actually do believe in DDR, but just happen to be confused about the conditions under which the law holds a person to be dead. Thus they believe that X is dead, and that organ procurement would be okay for that reason, but (mistakenly) that the law defines X as alive. If this is the case, then it is not true that people do not support the DDR.

Concerning irreversibly comatose and persistently vegetative patients, the Ohio study indicates that people are split as to whether to make exceptions in the DDR, or whether to redefine death so as to include such patients (or neither). Considering how many other things depend on the DDR, the best route would be the latter.

Lancet

Reviewer: A Martin

Title: Health care in Cuba and the manipulation of humanitarian imperatives

First Author: Garfield R

Citation: Lancet 2004; 364: 1007-1011

Summary: Denounces the current US administration's interest in using health and nutrition assistance as a means to affect regime change in Cuba, and warns of the dangers of allowing humanitarian aid to become a political instrument in a post-Castro Cuba.

Reviewer: A Martin

Title: Health and social justice

First Author: Ruger, JP

Citation: Lancet 2004; 364: 1075-1080

Summary: Egalitarian and utilitarian theories of justice focus on access to health care as an instrumental and/or intrinsic good. Rawls, Daniels, and others, maintain that justice should not address the distribution or value of health itself. In contrast, Ruger proposes an Aristotelian ("capabilities" approach, also inspired by Sen) theory according to which health itself is of intrinsic value. She draws out a number of policy implications of such a theory, and elaborates on Sen's notion that the capabilities approach need not establish an exact formula for judging inequalities in health, but instead may use a "partial ordering" or "incompletely theorised agreement."

Reviewer: Sabik, Lindsay

Title: A population-based nationwide study of parents' perceptions of a questionnaire on their child's death due to cancer

First Author: Kreicbergs, Ulrika

Citation: Lancet 2004; 364: 787-789

Summary: The proposed study to survey Swedish parents of children who had died of cancer was initially rejected by the local ethics committee. After pilot testing, the study was approved and questions regarding the effect of participation on the parents were added. 99% of parents surveyed found participation in the study valuable, and 68% said they were positively affected. 28% were negatively affected. The findings suggest that parents could generally see the opportunity to answer questions about their loss valuable 4-9 years after their child's death.

Reviewer: A Martin

Title: Global health and moral values

First Author: Alkire, S

Citation: Lancet 2004; 364: 1069-1074

Summary: Points out widespread assumption that "ethics are the foundation for global health initiatives." Reviews four schools of moral thought (humanitarianism, utilitarianism, equity, and rights) and indicates some of their strengths and weaknesses for purposes of designing and justifying global health policies. Argues that leaving the foundations of policy incompletely articulated can be useful for purposes of promoting consensus and advocacy, but maintains that clarity regarding this foundations is important because adopting a particular moral approach can affect the scope, implementation, and advocacy of policy.

Reviewer: Sabik, Lindsay

Title: Clinical trials in children

First Author: Caldwell, Patrina H Y

Citation: Lancet 2004; 364: 803-811

Summary: This review gives a thorough overview of the reasons to include children in trials/run pediatric RCTs, the risks and benefits typically involved, current practices in different countries, and roadblocks to expanding pediatric RCTs. In order to promote the expansion of necessary RCTs involving children, the authors call for better public education about the benefits of trials, as well as more standardized IRB review, and a national or international infrastructure for clinical research.

Reviewer: A Martin

Title: Clinical trial registration: a statement frm the International Committee of Medical Journal Editors

First Author: ICMJE

Citation: Lancet 2004; 367: 911-912

Summary: Argues against the selective reporting of research, proposes comprehensive trials registration, and announces that the eleven ICMJE member journals will adopt a trials-registration policy.

Reviewer: A Martin
Title: HIV-1 prevention in the context of increasing access to treatment
First Author: Wilson D
Citation: Lancet 2004; 364: 1038-1041
Summary: Response to July 3 Comment (Gayle & Lange) that recommended HIVE prevention services should be specifically tailored for people with HIV. Wilson et al argue that this tailoring needs to include addressing the sexual and reproductive health of people living with HIV and taking antiretrovirals.

Reviewer: A Martin
Title: Is "3 by 5" enough? Recalculating the global need for antiretroviral treatement
First Author: Anema A
Citation: Lancet 2004; 364: 1-4
Summary: Based on calculations of persons currently infected with HIV/AIDS, and the rate at which more people are being infected, the international community needs to aim beyond the WHO/UNAIDs target of treating 3 million by 2005.

Reviewer: A Martin
Title: Ethics of the Social Determinants of Health
First Author: Ruger, JP
Citation: Lancet 2004; 364: 1092-1097
Summary: Reviews and critiques the justice as fairness approach to the social determinants of health. Proposes as alternative Sen's Aristotelian "capabilities" approach, which sees health as having both contitutive and instrumental value. Layes out 5 recommendations generated by this approach (at times, I suspected that the distinction between the capabilities approach/recommendations and justice as fairness resulted from strawman conception of the latter).

Primary critique of justice as fairness: it promotes a "resource orientation" in public policy rather than a "results orientation" and thereby neglects bhoth the instrinsic value of health and the need for a truly broad--i.e. Not exclusively government-based--approach to sdh.

Reviewer: A Martin
Title: All children have a right to full access to treatment for cancer
First Author: Eden T
Citation: Lancet 2004; 394: 1121-1122
Summary: Correspondence: prompts WHO and other inter/national organizations to adopt two aims: 1) gain recognition of all drugs used to treat leukemia as essential drugs, 2) developing centers or groups of excellence in low-income countries to ensure the eficacy and safety of chemotherapy. The cure rate for acutre lumphoblastic leukemia has reached 80% in resource-rich countries, but 80% of children affected by cancer live in low-income countries, where the cure rate rarely exceeds 35%, and most receive no treatment.

Reviewer: zeke

Title: Making helath systems more equitable

First Author: Gwatkin, Davidson

Citation: Lancet 2004; 364: 1273-1280

Summary: Access to health systems seems consistently inequitable--well-off get more services of allmost all kinds, preventive, primary care etc. This papers reviews a lot of the data on this disparity.
How can this be changed?
1) Establish health system objectives that are relevant to the poor rather than the rich. E.g. progress in achieving an outcome based on % of poor who get it. This basically means attend to distributional effects of programs.
2) Highlight examples that work.
3) Most programs are supply driven rather than driven by empowring the poor. Little evidence this works.

Reviewer: Sabik, Lindsay

Title: National strategies wanted to plug the brain drain

First Author: Editors, The Lancet

Citation: Lancet 2004; 364: 556-556

Summary: An editorial outlining the problem of shortages in health care workers in developing countries, causes, and possible solutions. As premlimiary evidence as to what might be done to solve the problem, the authors cite the 80% return home rate of training programs at Fogarty International Center and explain briefly the benefits of Fogarty's programs.

Reviewer: Sabik, Lindsay

Title: The law of consent

First Author: Pincock, Stephen

Citation: Lancet 2004; 364: 489-490

Summary: This report gives an overview of the debate over the proposed Human Tissue Bill in Great Britain. The bill was drafted after it was discovered that organs of dead children had been used without proper consent in two hospitals. Yet, critics argued that it was written too hastily and did not make important distinctions, resulting in a sloppy bill that, if instituted, would impede medical research.

Reviewer: Sabik, Lindsay

Title: Ejecting the FDA from the courtroom

First Author: Editors, The Lancet

Citation: Lancet 2004; 364: 638-638

Summary: This editorial begins by noting that, despite traditional Republican support of limited government, the Bush administration has favored government intrusion into health matters. In particular, the editors point out the FDA's role in judicial matters and FDA decisions that seem to have been based on special interests rather than science. They call for separation of powers in the Bush administration and say that the FDA should stay out of legal matters.

Reviewer: Sabik, Lindsay
Title: Health-care provision and the path out of poverty
First Author: Wynd, Shona
Citation: Lancet 2004; 364: 562-564
Summary: Commentary on the importance of paying attention to refugees and internally displaced populations in relief and development work.

Reviewer: Sabik, Lindsay
Title: The World Bank is finally embracing science
First Author: Editors, The Lancet
Citation: Lancet 2004; 364: 731-732
Summary: This editorial emphasizes the importance of impact assessment for development projects and commends the recent practice of conducting randomized trials to evaluate the success of various policies. The author points out a number of unanswered questions about this process, though, including that of how the findings will be disseminated.

Reviewer: A Martin
Title: Bioethics, health, and inequality (comment)
First Author: Lane M
Citation: Lancet 2004; 364: 1017-1017
Summary:

Reviewer: A Martin
Title: Bioethics, health, and inequality
First Author: Berlinguer G
Citation: Lancet 2004; 364: 1086-1091
Summary: Hodgepodge article that starts out by drawing distinction between "frontier" and "everyday" bioethics and promising to show how the intersection of these two areas could give rise to "stimulating philosophical debates." Main point seems to be that issues of justice ("everyday" bioethics?) are relevant to high-tech stuff ("frontier" bioethics?)

Reviewer: A Martin
Title: Keep genome data freely accessible
First Author: editors, Lancet
Citation: Lancet 2004; 364: 1099-1100
Summary: Describes and defends recent recommendation by National Academies of Science to maintain the current policies of genome-sequence data repositories, which make gene data freely accessible.

Reviewer: A Martin

Title: Rediscovering human dignity

First Author: Horton R

Citation: Lancet 2004; 364: 1081-1085

Summary: Defends dignity as the appropriate focus of social justice in general and global public health policy in particular. Draws on a range of theorists to elucidate the concept of dignity and its value (Isaiah Berlin, Giambattisti Vico, Kant, Rabbi Jonathan Sacks, Oswei Temkin, Georges Canguilhem, Thomas Hill, …)

Reviewer: Sabik, Lindsay

Title: Further from Washington: can Celtic UK renew the NHS?

First Author: Hart, Julian Tudor

Citation: Lancet 2004; 364: 633-635

Summary: The author outlines the history of the the views of Ireland and Wales in the NHS and gives a scathing attack of the US model. He states that "the best place for public health is as far as possible from Washington, where all that is profitable is acceptable, and nothing is acceptable that is not profitable." He argues that the NHS should turn to its own history and practice or at least to countries with similar social traditions, rather than to the US for guidance.

Reviewer: Sabik, Lindsay

Title: Asking parents unaskable questions

First Author: Burnell, Richard H

Citation: Lancet 2004; 364: 737-738

Summary: The authors comment on the study in the same issue which surveyed parents whose children had died of cancer. The study was initially rejected by the local ethics committee, and the authors argue here that while informed consent should be an ongoing process in a study involving bereavement and that researchers must be sensitive to the parents' reactions, it is not the case that such surveys will generally be harmful to those surveyed. In fact, speaking about a child's death, particularly in order to help others going through the same experience, can be therapeutic for the parents.

Reviewer: Sabik, Lindsay

Title: Practicalities of consent

First Author: Laing, Ian A

Citation: Lancet 2004; 364: 659-659

Summary: The authors of this letter object to guidelines issued by the NHS in Scotland regarding obtaining informed consent from parents as part of the new Universal Neonatal Hearing Screening program. The authors contend that to fulfill the consent guidelines as they stand would take at least 20 minutes of discussion per case, adding up to 4000 hours per year. They calculate that a unit delivering 6000 infants each year would have to hire 6 additional staff members simply to obtain consent, which they believe is unreasonable. They think patient responsibility should play a bigger role, and that these guidelines are setting an unwelcome precedent.

Reviewer: zeke

Title: Health financing to promote access in low income settings--how much do we know?

First Author: Palmer, Natasha

Citation: Lancet 2004; 364: 1365-1370

Summary: To make health care available through public schemes requires knowing how financing arrangments affect use by different groups.
Review of data from 1995 onward shows most studies to be methodologically weak--lack of controls and controlling for SES.
1) Introducing fees for services--even when tied to improved quality-- produced an overall fall in use of services in African studies.
2) No good data on what community based insurance or pre-payment does.
3) Micro insurance increases use but used predominantly by higher SES people.
4) Some good results with programs that pay poor people to use health care services--mostly in Latin America.

New England Journal of Medicine

Reviewer: Greg

Title: Protecting the Uninsured

First Author: Thorpe, KE

Citation: New England Journal of Medicine 2004; 351: 1479-1481

Summary: This is a brief review of (1) the economic and demographic data about uninsured Americans, and (2) the Kerry and Bush proposals for increased coveraged and reduced health care costs. You might as well ignore half of it now.

Reviewer: Greg

Title: Controlling Health Care Costs

First Author: Ginsburg, PB

Citation: New England Journal of Medicine 2004; 351: 1591-1593

Summary: The author argues that neither the Kerry nor Bush proposals for reduced health care costs deal with the core problems. As he sees it, "new technology" includes new diagnostics that are costy & ones that are cheaper per unit and more effective, leading to increased rates of use.
Finally, he outlines 4 basic strategies to reduce spending: (1) increase efficiency of delivery; (2) increase incentives for patients to limit their use; (3) increase administrative control of medical services; and (4) limit total resources available for health care.

Reviewer: Greg
Title: Ethics of Embryonic Stem Cells
First Author: Various
Citation: New England Journal of Medicine 2004; 351: 1687-1690
Summary: A series of correspondences based on Sandel's piece in NEJM (15 July).

Robert P. George (from PCB) writes back that "the flaw in Sandel's argument is that human embryos differ from other human beings not in the kind of entity that they are, but in their stage of development."

Sandel's reply: since we all develop in a biologic mother, this is an "essential characteristic of human life." This motivates viewing the emrbyo as potential human life, and not a person. Ben characterizes this claim as "stupid."

Reviewer: greg
Title: Bankrolling Stem-Cell Research with California Dollars
First Author: Yamamoto, KR
Citation: New England Journal of Medicine 2004; 351: 1711-1713
Summary: A short summary of California's Proposition 71 that outlines specifics about potential basic science advances and limits and how grants would be distributed.

Reviewer: greg
Title: Financing Medicare in the Next Administration
First Author: Newhouse, JP
Citation: New England Journal of Medicine 2004; 351: 1714-1716
Summary: Some facts: In FY 2005, Medicare will spend $8000 on each of 41 million beneficiaries. Since 1946, American voters have tended to be reluctant to allocate over 18% of GDP to total federal spending.

Newhouse's sarcastic proposal: assume a "graying society" might be willing to increase the 18% ceiling.

Reviewer: greg

Title: Financial conflicts of interest in physicians' relationships with the pharmaceutical industry-self-regulation in the shadow of federal prosecution

First Author: Studdert, DM et al.

Citation: New England Journal of Medicine 2004; 351: 1891-1900

Summary: This paper addresses the prominent issue of physicians' relationships with industry. In recent years, there has been much greater oversight of such relationships, motivated principally by the (1) increased influence of pharmaceutical companies, (2)the Medicare prescription drug benefit, which does not want to see increased public expenditure, and (3) a greater body of federal law on fraud and abuse.

Currently, pharma. spends $12 billion/year on payments and gifts for physicians, it funds over 70% of clinical trials, and shoulders 50% of CME costs.

The federal government has oversight on these relationships through the "federal anti-kickback statute." A recent court case that earned much media attention was government's case against TAP Pharmaceuticals, which manufactured Lupron. The basic fraud scheme was: TAP encouraged urologists to bill Medicare for Lupron at the average wholesale price, when they were receiving Lupron at discounted prices or free. TAP settled with the government in 2002.

Since TAP, there has been increased self-regulation. PhRMA, the industry trade group, established stronger, more specific ethical guidelines regarding support for medical meetings, consulting relationships, and urged gifts to be under $100 and to be ostensibly for patient benefit (think stethoscope).

Such self-regulation has been watched closely by the government, with the Inspector General issuing its own analysis and policy recommendations.

The authors argue that self-regulation needs to continue to happen if physicians and industry want to avoid overwhelming scrutiny from the govt.

Science

Reviewer: Krohmal, Ben

Title: NIH Proposes Temporary Ban on Paid Consulting

First Author: Jocelyn Kaiser

Citation: Science 2004; 306: 27-27

Summary: News piece…self explanatory

Reviewer: Krohmal, Ben
Title: Stem Cell Claims Face Legal Hurdles
First Author: Gretchen Vogel
Citation: Science 2004; 305: 1887-1887
Summary: This news piece discusses discrepancies between US policies allowing the patenting of discoveries from embryo research, and those of the European Patent Office, which has rejected applications for such patents.

Reviewer: Krohmal, Ben
Title: Clinical Trials or Exploitation
First Author: Ignazio Marino, Claudia Cirillo
Citation: Science 2004; 306: 54-55
Summary: This letter to the editor argues for regulations mandating that benefits be provided to participants in clinical trials performed abroad after the conclusion of the trial. The letter really makes no new points about this matter…it's not clear why it was published.

Reviewer: Krohmal, Ben
Title: Thinking About Caring About Animals
First Author: David Magnus
Citation: Science 2004; 306: 58-59
Summary: The reviewer praises the book Animal Rights: Current Debates and New Directions, edited by Cass Sunstein and Martha Nussbaum. The reviewer agrees with arguments in the book to the effect that exclusions of some species from US animal welfare laws is arbitrary, and seems sympathetic to the conclusion that much human behavior towards animals is based upon sentiment rather than rational justification.

Reviewer: Krohmal, Ben
Title: Neuroscience and Neuroethics
First Author: Donald Kennedy
Citation: Science 2004; 306: 373-373
Summary: This lead editorial raises potential ethical concerns arising from advances in neuroscience. Among these are issues of authenticity in the context of mood altering drugs, justice in the context of possible cognitive enhancement therapies, privacy in the context of increasingly informative brain scanning technology, and freedom and responsibility in the context of a more complete understanding of the relation between brain states and choice. The editor raises these issues, but makes no real arguments or recommendations about them.

Reviewer: Hampson
Title: Intellectual Property: Commons Based Strategies and the Problems of Patents
First Author: Benkler, Yochai
Citation: Science 2004; 305: 1110-1111
Summary: Could not access article for some reason.

Reviewer: Hampson

Title: NIH Declines to March In on Pricing AIDS Drug

First Author: Malakoff, Dave

Citation: Science 2004; 305: 926-926

Summary: News:
AIDS activists had wanted Zerhouni to invoke the 1980 Bayh-Dole Act which allows the government to reclaim patents on taxpayer-funded inventions if companies aren't making the resulting products available to the public. Specifically at issue was the drug Norvir made by Abbott Laboratories, which was developed with a $3.5 million NIH grant. Last year Abbott increased the prince of some formulations by up to 400%. Zerhouni has refused to reclaim patents, citing that a "march-in" is not an appropriate means of controlling prices and that pricing issues are best "left to Congress."

Reviewer: Hampson

Title: Intellectual Property: Commons-Based Strategies and the Problems of Patents

First Author: Benkler, Yochai

Citation: Science 2004; 305: 1110-1111

Summary: An article offering a solution to the problems caused by overprotection of patents, such as impeding scientific research through "anticommons" effects and imposing cost barriers on access to medicines.
Benkler examines "commons-based" production (ie, free software), where no one uses exclusive rights to attain payment and cooperation is achieved for reasons other than monetary value, such as relying on indirect rewards. Scientists already use nonproprietary frameworks (Ensembl Genome Browser, Public Library of Science).

Proposal 1: Publicly Minded Licensing
Patent royalty and licensing revenue provides an insignificant portion of total university revenues
All universities (in millions): total $227,000
Licensing/royalties: $1,270
Government grants/contracts: $31,430
Universities can adopt two varieties of license:
Open research license (ORL)
1.University would reserve a right to use and nonexclusively sublicense its technology for research and education.
2.License and sublicensee would grant a nonexclusive license to the university to use and sublicense all technology that the licensee develops based on university technology for research and education only.
Developing country license (DCL)
Add development, manufacture, distribution of end-product drugs if distribution is limited to developing nations, permitting generics to manufacture for developing nations
Benefits: alleviate anticommons effects and patent-based limits on global distribution, would not significantly impace pharmaceutical revenues; universities/scientists would lose almost no revenue from end products but would lose remote likelihood of revenue-generating patents; research impediments would be reduced; improved public perception of universities as public interest organizations.

Proposal 2: Peer Production
Scientists would identify components of scientific production and modularize tasks to minimize burden on one contributor. Everyone finds a few minutes or hours to contribute to the larger goal (they would do this because they value the potential knowledge gained). Experiments on widely available equipment can be designed to fit peer production--one person does the experiement and puts the results on the web, another person reviews and analyzes the results. Repeat contributors would become coauthors on papers based on the results.
Benefits: Increase ability to pursue science which cannot be paid for under the present system.