

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.

**Shalowitz DI, Garrett-Mayer E, Wendler D.** How should treatment decisions be made for incapacitated patients, and why? *Public Library of Science Medicine* 2007;4(3):e35. Available from: URL: <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0040035>.

Reliance on those people who know an incapacitated patient best to make that person's treatment decisions seems to promote patient autonomy by maximizing the chances that the patient's preferences will guide what treatments he or she receives. It also seems to respect their status as vital individuals in the patient's life and may provide comfort at a difficult time. However, recent data throw doubt on the accuracy of surrogate decisionmaking. A recent study analyzed 16 empirical English-language studies and found that surrogates accurately predict patients' treatment preferences only about 68% of the time. The empirical data also suggest that the two most frequently endorsed methods for improving surrogates' predictive accuracy—reliance on surrogates designated by the patient rather than the default next of kin and explicit discussions of patients' treatment preferences—are ineffective.

These authors asked whether a more accurate decisionmaking method would be to use a population-based computer model based on the treatment preferences of individuals similar to the patient. Their model does not assume that all individuals of a given gender, race, or religion have the same medical treatment preferences. Rather, the indicator simply incorporates those factors that the data show are associated with particular medical treatment preferences, along with the strength of these associations. Relying on population-based treatment indicators can, of course, lead to errors. Members of any given group, no matter how narrowly defined, will invari-

ably have different treatment preferences in some cases.

Using the U.S. population as their model base, they incorporated the presumptions that many Americans want life-saving interventions when there is at least a 1% chance that the treatment will lead to what they consider an acceptable health state, which they interpreted as being the ability to reason, remember, and communicate. Conversely, the preliminary population-based treatment indicator predicts that patients will not want life-saving treatments when there is greater than a 99% chance that, following the treatment, they will be left permanently unable to reason, remember, or communicate. The authors tested their model with 29 scenarios against the decisions made by surrogates. They found that their model predicted patients' treatment preferences with essentially the same accuracy as surrogates. Overall, the treatment indicator correctly predicted the patient's treatment preferences in 78.5% of cases, whereas, in these same scenarios, surrogates correctly predicted the patient's treatment preferences in 78.4% of cases.

The authors conclude that their model might supplement the surrogate decision-making process. In this approach, treatment decisions for incapacitated patients would still be made in consultation with the patient's surrogate. The population-based treatment indicator would be used to help diminish uncertainty surrounding the patient's wishes by identifying the treatment preferred by similar patients. They also suggest that it could be used in place of surrogates, which could be an excellent option for those without identifiable surrogates. The real effect of such models may be that although surrogates and clinicians and computer models may now perform at an equivalent level of accuracy, computer programs can "learn" as they acquire substantially more data. All indi-

cations are that, *eventually, even the bioethics community may be replaced by machines.*

**Okike K, Kocher MS, Mehlman CT, Bhandari M.** Conflict of interest in orthopaedic research. An association between findings and funding in scientific presentations. *Journal of Bone & Joint Surgery—American* 2007;89(3):608–13.

With financial conflict of interest being associated with an increased likelihood of positive study outcomes, these investigators looked at the association between types of declared conflict of interest and reported study outcomes in orthopedic research. Three orthopedic surgeons with advanced training in clinical epidemiology analyzed all abstracts presented orally at the 2001 and 2002 Annual Meetings of the American Academy of Orthopedic Surgeons. They graded each abstract's findings as positive, negative, neutral, or not applicable and noted the associated self-reported conflict of interest.

They found that presenters reported conflicts of interest in association with 40.8% (212) of 519 abstracts. Whether the conflict of interest related to their employee status or to royalties, stock options, or consultancies varied significantly by the authors' subspecialty field ( $p < .001$ ). The overall rate of positive study results was 84.0% (436 of the 519 abstracts). Positive results were more common in studies authored by individuals with a conflict of interest related to royalties (98.4%; 60/61) compared with 88.0% (381/433) for studies without a conflict of interest related to royalties ( $p = .02$ ), by those with a conflict of interest related to stock options (100.0%; 29/29) compared with 84.7% (394/465) without this conflict of interest ( $p = .04$ ), and in studies authored by individuals with a conflict of interest related to consultant or employee status (97.8%; 91/93) compared with 89.0% (357/401) without this conflict ( $p = .01$ ). One note: Positive findings were not more common in studies authored by individuals with a conflict of interest related to research or institutional funding (93.5%; 143/153) compared with 91.8% (313/341) of those without this funding source ( $p = .65$ ). In the multivariate analysis, the factors that remained significant predictors of positive outcomes were royalties ( $p = .002$ ) and consultant or employee status ( $p = .038$ ).

This led to the authors' conclusion that self-reported conflicts of interest are common in orthopedic research, particularly in the subspecialty fields of adult reconstruction of the knee, adult reconstruction of the hip, and spine. Most importantly, *presentations authored by individuals with a conflict of interest related to employee status or to royalties, stock options, or consulting were significantly more likely to describe positive findings.* Although there may be distinct benefits associated with industry support of orthopedic research, safeguards must be established to maintain public trust in the medical research establishment.

**Smith JL, Cervero RM, Valentine T.** Impact of commercial support on continuing pharmacy education. *Journal of Continuing Education in the Health Professions* 2006; 26(4):302–12.

What effect does pharmaceutical industry financing have on the continuing education of pharmacists? Because many pharmacists have a significant influence on hospital and practice formularies, there should be significant interest in the potential conflict of interest when there is commercial support for their continuing education programs. These authors investigated the effect of commercial support on the provision and perceived outcomes of continuing pharmacy education.

These investigators administered a 64-item online survey to a national sample of accredited programs and nationally known providers of continuing pharmacy education; they got a 34% usable response rate. Among the respondents, approximately 86% of providers and 43% of programs received commercial support. Although the Accreditation Council for Pharmacy Education requires that providers review instructional content and materials for commercially supported programs before delivery, only 43% always did so. Respondents agreed that commercial support has consequences for provider organizations, pharmacists, and patients, such as increased cost and use of drugs and financial dependency of providers and participants on industry support. Not surprisingly, the authors concluded that commercial support of continuing education is widespread within the pharmacy profession, affects continuing education programs, and is perceived to have significant educational and noneducational consequences. They be-

lieve that *the pharmacy profession should ensure that continuing education guidelines unambiguously specify what is permissible when receiving commercial support*. Isn't it about time that pharmacists follow all other healthcare provider models for continuing education?

**Orlowski JP, Hein S, Christensen JA, Meinke R, Sincich T.** Why doctors use or do not use ethics consultation. *Journal of Medical Ethics* 2006;32(9):499–502.

Although some physicians regularly use ethics consultations, others are reluctant to use these services. These authors tried to determine factors that may influence doctors to request or to not request an ethics consultation. To do so, they distributed a questionnaire, with answers on a Likert scale (*strongly agree to strongly disagree*) to doctors on staff at the University Community Hospital in Tampa, Florida. They got a 65% response rate, with the demographics being similar for the group saying that they do/would use ethics consultation when indicated and the group saying that they do not/would not use such consultation. There were no statistically significant

differences between the user and the non-user groups in terms of their opinions about whether ethics consultants had extensive training in ethics or participated in ethics educational opportunities. On the issue "Ethics committee members or consultants cannot grasp the full picture from the outside," the nonusers were neutral, whereas the users somewhat disagreed ( $p = .012$ ). More significant was the difference between surgeons and nonsurgeons, when logistic regression analysis was used; surgeons who believed that ethics consultants could not grasp the full picture from the outside were highly likely to not use them ( $p = .0004$ ). Nonusers of ethics consultations thought that it was their responsibility to resolve issues with the patient or family (72.2% agree,  $p < .05$ ). Users of ethics consultation believed in shared decisionmaking or the importance of alternate points of view (90.8% agree,  $p < .05$ ).

These authors' conclusions were that *doctors who believe in shared decisionmaking use ethics consultations, whereas those who tend to think that it is their responsibility to resolve issues with patients and families and that they are already proficient in ethics do not*.