

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.

Light DW. Good managed care needs universal health insurance. *Annals of Internal Medicine* 1999;130(8):686–9.

The “American way” of providing voluntary health insurance through employers is falling apart. Employers have shifted large proportions of premiums and payments for medical services to their employees. Termed “backdoor disinsurance,” this practice heavily discriminates against those who most need medical services and reduces the chance that clinicians will be paid for treating them. It prices many lower-income workers out of economically meaningful access to health insurance. This article argues that this practice is typical of “pernicious managed care,” where tactics used to save money include obstructing access to specialists, tests, and procedures; underpaying providers and rewarding them for doing less; stalling or refusing to pay bills for services already given; and driving away patients with serious medical problems.

This behavior departs from the four elements of stability needed for “good clinically managed care”: continuity of care, stable teams to develop and deliver integrated care programs, a patient population that remains in place long enough to develop working relationships with providers, and health insurance coverage that does not change or evaporate for the entire population. This last element is essential for the other three, and as this article points out, without some type of unified national program, it is unlikely to exist no matter what patchwork fixes are instituted. Despite a \$100 billion government subsidy to induce employers to offer health insurance, U.S. employers seem tired of paying for health benefits that force them to increase prices and make their products less competitive in world markets. The United States is the last western country to use the antiquated

(and elsewhere repudiated), enormously complex system cobbled together with pieces of government, employer insurance, private insurance, and private payment schemes.

The single, universal health-funding program this article suggests as a solution need not be a “single-payer” system, although that is the most efficient administrative model. It would, unlike the failed managed care programs, be able to establish a simple, universally fair healthcare system that could also result in large-scale cost savings. Although the author continues to call the unified system “managed care,” it is actually what has been termed “socialized medicine.” We are stumbling toward it now and afraid to embrace it. For everyone’s benefit—patient, provider, and payer—it’s time we admit that in the end that is the only course of action. The sooner we do it, the better.

Karlawish JHT, Hougham GW, Stocking CB, Sachs GA: What is the quality of the reporting of research ethics in publications of nursing home research? *Journal of the American Geriatric Society* 1999;47:76–81.

Nursing home patients often represent a vulnerable population for human subjects research. While not examining how well ethics have been applied to this group, this study examines an important derivative—the reporting of research ethics in published research reports. The authors examined 45 publications cited in Medline with research conducted between 1992 and 1996 for four common research standards: (1) justification of the use of nursing home residents, (2) institutional review board (IRB) review, (3) nursing home committee review, and (4) whether informed consent was obtained.

They found that all reviewed publications reported justifications for using nursing home residents and 36 reported that informed consent was either obtained or waived. However, only 18 of the reviewed publications reported that the study had undergone IRB review and only six reported that a nursing home committee had reviewed them.

When the authors studied each journal's author instructions, they found a positive association between the detail of instructions in each ethical area assessed with the degree to which the journal's articles conformed to the ethical standards. This suggests that ethical deficiencies in research articles involving nursing home residents can be corrected by adopting an explicit set of research ethics instructions for authors and through the process of peer review and editing. No doubt this also holds true for many other medical journals and studied populations.

Flanagin A, Carey LA, Fontanarosa PB, Phillips SG, Pace BP, Lundberg GD, et al. Prevalence of articles with honorary authors and ghost authors in peer-reviewed medical journals. *JAMA* 1998;280:222-4.

Publish or perish has long been an academic axiom. Authorship of a scientific article in biomedical publications establishes accountability, responsibility, and credit. How often, though, are the named authors not actually involved in any aspect of preparing the piece (honorary authors) or have been assisted by individuals who substantially contributed to the work but were given no credit (ghost authors)? This study used a 21-item questionnaire to obtain information about article preparation. The authors contacted 1,179 corresponding authors of articles published in the United States in 1996 in three large circulation, general medical journals considered to have "high impact" on the profession, and in three smaller circulation, specialty journals. They had a 69% response rate (809 authors).

Overall, 19% of the articles had honorary authors. Honorary authorship was greater among review articles than research articles. Honorary authors found a place in 25% of all articles in the *Annals of Internal Medicine* (and 28% of editorials), and in 23% of all articles in both the *American Journal of Medicine* and *JAMA* (where most of this article's authors work). Nearly one-third of *JAMA* editorials (32%) and review articles (30%) had honorary authors.

Overall, 11% of the articles had ghost authors (2% had both honorary and ghost authors). Of all articles in the *New England Journal of Medicine*, 16% had ghost authors, but this increased to 26% for research articles. In the *Annals of Internal Medicine*, 15% of articles had ghost authors, with spectral contributions in 20% of research articles.

Misappropriation of authorship (either honorary or ghost authorship) is incompatible with the principles, duties, and ethical responsibilities involved in scientific publication. Yet as has been shown in previous studies, individuals involved with more than one-fourth of the multiauthored pieces in prestigious U.S. medical journals violate this ethical standard. It seems that we have a long way to go before any of the training in scientific integrity currently underway takes hold. With these types of role models to look to, we may be wasting our time.

McCarthy GM, Koval JJ, MacDonald JK. Factors associated with refusal to treat HIV-infected patients: the results of a national survey of dentists in Canada. *American Journal of Public Health* 1999;89(4):541-5.

Prior studies have shown that about one-third of Canadian dentists (and between 30% and 79% of dentists elsewhere) will not treat patients they know have HIV infections. Is this true? And if so, why won't Canadian (and other) dentists treat patients infected with HIV? To find out, a stratified random sample of 6,537 dentists, more than one-third of all dentists licensed in Canada, was surveyed (and 66.4% responded). Of the respondents, 32% had knowingly treated HIV-infected patients in the last year and 16% would refuse to treat HIV-infected patients. Overall, one in six Canadian dentists reported that they would refuse to treat HIV-infected individuals.

Of the respondents, 81% were willing to treat HIV-infected individuals, 86% would treat users of injectable (illicit) drugs, 87% would treat patients infected with hepatitis B, 94% would treat homosexual and bisexual individuals, 94% would treat those with sexually transmitted diseases, and 97% would treat recipients of blood or blood products.

The best predictors of those dentists who refused to treat HIV-infected individuals were the lack of a sense of ethical responsibility (odds ratio = 9.0) and items related to fear of cross-infection or a lack of knowledge about HIV. Older dentists were less likely to be willing to treat HIV-infected

patients (age 50–59 = 20.7% refusal; age 60+ = 26.9% refusal). Those in the Prairies/Northwest Territories were less likely to be willing to treat this group (20% refusals) than were those in other parts of Canada.

The authors suggest that basic information about disease transmission and increased ethics instruction at the undergraduate, graduate, and continuing education levels would decrease dentists' unwillingness to provide services to certain groups.

Vincent JL. Information in the ICU: are we being honest with our patients? The results of a European questionnaire. *Intensive Care Medicine* 1998;24:1251–6.

What attitudes do western European intensivists have toward patient–physician communication and informed consent? This author surveyed 1,272 members of the European Society of Intensive Care Medicine (40% response rate, or 504 replies). Among all respondents, only 25% said that they would always give complete information to a patient about diagnosis, treatment, and prognosis, although 35% felt that they should. These figures were similar regardless of the respondent's age, sex, or religious belief, but varied widely by national origin (and the medical and societal cultures in which they reside). The Netherlands stood out, with 65% of respondents saying that they always give their patients this complete information. In Italy (17%), Spain (16%), Austria (12%), Germany (11%), and Greece (11%), few intensivists always provide this information. Respondents in Scandinavia (36%), Switzerland (36%), Portugal (32%), the United Kingdom (28%), France (24%), and Belgium/Luxembourg (21%) fell between these extremes.

Following an avoidable mistake, only 32% of these European intensivists would pro-

vide complete details, although 70% felt that they should do so. Male doctors were more likely than were female doctors to give the exact story (34% versus 20%). Of those in the Netherlands, 72% would provide exact details, as would 58% in Scandinavia. In Italy, however, only 11% would tell patients and even fewer would in Spain (9%).

Intensivists in the other countries varied between these extremes: Switzerland (48%), the United Kingdom (45%), Austria (31%), Germany (30%), France (19%), Belgium/Luxembourg (17%), Portugal (17%), and Greece (16%).

If a patient with decisional capacity refused treatment, 75% would accept this decision, although 19% would override their patient's wishes and intervene. Male doctors were more likely than were female doctors to accept the patient's decision (77% versus 60%). For interventions deemed "vital," intensivists in the United Kingdom (96%) would abide by their patients' wishes, as would 92% in Scandinavia and 91% in the Netherlands. In Greece, however, only 33% would abide by these preferences, as would only 47% in France and 50% in Italy. Intensivists in the other countries varied between these extremes: Germany (88%), Switzerland (88%), Austria (77%), Spain (77%), Belgium/Luxembourg (66%), and Portugal (63%). For "non-vital" interventions, the respondents were more willing to abide by patient wishes.

As this study suggests, describing European physicians as "paternalistic," as is often done, is an unfair generalization. Medical behavior conforms to the regional culture, best (or at least most easily) described country by country. One must wonder about the regional variations in this type of behavior among the areas of the large nations, such as the United States.