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 editors Kenneth V. Iserson and Barry Morenz at bmorenz@email.arizona.edu.

Lorek A, Ehntholt K, Nesbitt A, Wey E, Githinji C, Rossor E, Wickramasinghe R. The mental and physical health difficulties of children held within a British immigration detention center: A pilot study. *Child Abuse & Neglect* 2009;33(9):573–85.

Current British law allows for families with children subject to immigration control to be detained indefinitely. Detention may occur while the family's claim for asylum or other legal right to remain in the United Kingdom is determined, and if the claim is denied, until their removal from the United Kingdom. Serious concerns have been raised about the well-being of children held in immigration detention facilities, and Australian research has indicated that detention is not in the best interest of the child. The authors aimed to conduct a pilot study of the mental and physical health of children detained within a British immigration center. Twenty-four children, including 12 boys and 12 girls, ages 3 months to 17 years, from 16 different families were assessed with their parents or caregivers after being referred by a legal charity. The children had been held in custody 11–155 (median 43) days. Thirteen were evaluated by a pediatrician alone, 4 by a psychologist alone, and 7 by both using semistructured clinical interviews. The psychologist also applied standardized self-report questionnaires, relying more heavily on information provided by parents for younger children. Of the 11 children who underwent psychological assessment, all reported symptoms of anxiety and depression. Common findings included sleep disruption, reduced appetite, somatic complaints such as headaches and abdominal pain, feelings of fear and confusion, problems with peer relationships and behavioral difficulties. On the Strengths and Difficulties Questionnaire (SDQ), 73% of children met criteria for psychiatric ''caseness'' with approximately one third in the ''borderline'' category and two thirds in the ''abnormal'' category on the total difficulties score. Pediatric assessment of physical health revealed that 8 out of 20 children had lost weight. Other children gained more weight than usual. Six had missed recommended follow-up healthcare appointments, and 2 required hospital care. Most of the children reported recent onset or exacerbation of physical symptoms. Concerns regarding nutrition, preventative health and immunization, development, education, and child protection were raised. Though children evidenced high levels of mental and physical health difficulties, access to appropriate assessment, support, and treatment was limited. *Initial data suggest detention has a negative impact on the mental and physical health of children. Further research is needed to inform policies regarding the detention of children for purposes of immigration control.*

Gundermann C, Meier-Hellmann A, Bauer M, Hartmann M. Der Einfluss einer krankenhausinternen Richtlinie auf die Einstellung von Arzten zur pharmazeutischen Industrie. [Effects of a mandatory guideline that prohibit hospital doctors from accepting any form of benefits in any form from the pharmaceutical industry]. [German] *Deutsche Medizinische Wochenschrift* 2010; 135(3):67–70.

Several German hospitals have issued guidelines regulating their staff members' interactions with the pharmaceutical industry. These authors investigated whether hospital-based physicians in institutions with guidelines and those without guidelines differ in their attitude toward the pharmaceutical industry. They anonymously surveyed all physicians working in intensive care units of a hospital with and without guidelines about their dealings with the pharmaceutical industry. The response rate was 64.9% (37/57) and 55.1% (59/107), respectively.

They found that in the hospital with guidelines, about one half of the surveyed physicians were carrying a pharmaceutical advertising gift with a company logo.

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Those in the institution without guidelines were carrying an average of 1.2 of these advertising gifts ($p = .026$). Whereas 49% of doctors with guidelines did not have any ethical concerns about accepting advertising gifts, 81% of those in the hospital without guidelines saw no problems accepting these gifts ($p = .001$; RRR = 0.65; 95% CI = 0.48–0.91).

They also found a difference in one of the most difficult educational areas for physicians: the influence of gifts on actions. In the institution with guidelines, 70% of surveyed physicians believed that the advertising practices of the pharmaceutical industry had no influence on their prescribing behavior compared with 92% of those in the hospital without guidelines ($p = .010$; RRR = 3.6; 95% CI = 1.36–9.52). Both physician groups, however, were convinced that other doctors are more influenced by the pharmaceutical industry than they are themselves (51% with and 37% without guidelines, $p = .207$).

Assuming that the extensive research on gift giving behavior is correct and that physicians' prescribing practices are influenced by industry-sponsored gifts, this study supports the idea that setting hospital guidelines on relations with the pharmaceutical industry may reduce this influence. The experience, however, is that most institutions will fail to take action, either because of cowardice, fear, or greed.

Dwarswaard J, Hilhorst M, Trappenburg M. The robustness of medical professional ethics when times are changing: A comparative study of general practitioner ethics and surgery ethics in The Netherlands. *Journal of Medical Ethics* 2009;35:621–5.

Social values, such as views of race and gender equality, homosexuality, abortion, and euthanasia, have changed since the 1950s. In like manner, the authors hypothesize that medical professional ethics during this same time period have changed as well. The article considers how two social changes, the balance between work and home life and more educated, informed, and less deferential patients, have affected medical professional ethics since the 1950s. The authors look at two medical specialties in The Netherlands, general practitioners, who presumably are more deeply involved in society, and surgeons, who primarily work in hospitals and are more specialized and have less personal contact with patients. The authors hypothesize that general practice physicians' ethics will change more quickly than those of surgeons, who are somewhat more isolated from social changes. To answer these questions, the authors performed a qualitative analysis of Dutch medical journals from 1940 to 2008.

The authors note that the first few years after World War II in The Netherlands were "all work and no play," but in the latter 1950s and 1960s, economic progress brought prosperity and a greater desire for luxuries and vacations. Then in the 1970s more women entered the labor market, including mothers of young children. Paralleling these general social trends, both general physicians and surgeons in the 1950s and early 1960s were portrayed in medical journals of the time as follows, "A good doctor is fully dedicated to his patients, puts their interests before his own, and works long hours." Later in the 1960s general physicians began to think about reorganizing their work from solo to group practices. As quoted in one journal in 1960, "The group practice system allows every doctor a free afternoon in which he can practice a personal hobby." In another medical journal in 1968, a general physician confessed, "We're not that happy anymore with the role of the counselor available at all hours, even though some patients still expect us to fulfill that role." In 1971 only 2% of general physicians worked in a group practice or health center, but by 2007, 80% worked in such practices. During the same time period, the number of female general physicians increased from 4.2% to more than 35%, and an increasing number of general physicians were working part-time. Core values of general practice professional ethics, which include continuity of care, personal attention to the needs of individual patients, and personal knowledge of patients, have been retained but with a new meaning. For instance, continuity of care no longer involved having general physicians knowing a patient's personal history but came to mean that there is a general physician available at all hours but not necessarily the same personal physician a patient might ordinarily consult with. Change for surgeons has been slower. The authors in surgeons' journals observe that "humane working conditions for doctors will threaten the continuity of care for patients," and in the 1990s only slightly over 12% of

newly registered surgeons were females. Yet, younger surgeons seem to be accepting limited working hours and availability.

Additionally, the role of patients in their own healthcare decisionmaking changed and was encouraged by general physicians over the past 50 years. As the authors quote one journal, ''The goal of medicine is not to formulate objectives or to make decisions about healthcare; 'the doctor knows best' does not fit in this view.'' General physicians were actively educating patients and encouraging them to play a more autonomous role, as noted in the following quote from a general practice journal, ''One of the basic rules of healthcare is to increase patient autonomy and independence.'' Surgeons' attitudes were different, as the authors indicate: ''Surgeons argue that the truth should not be forced on patients.'' Change took place in surgery but the move away from paternalistic medicine to shared decisionmaking with patients was resisted longer.

The authors note limitations to their work, as it was qualitative versus quantitative and that editorial policies in general physician journals and surgical journals may be different and were not investigated. The authors note that new professional ethics may be better and inevitable in view of social change but there may be value in opposing or resisting some forms of social change as well. *The authors underscore that as society evolves, new professional ethics may be required. Being adaptable and flexible like The Netherlands' general physicians is meritorious, yet there is also value in clinging to cherished values and being reluctant to easily change one's core medical professional principles, as was the case with The Netherlands' surgeons.*

Grosse SD, Rogowski WH, Ross LF, Cornel MC, Dondorp WJ, Khoury MJ. Population screening for genetic disorders in the 21st century: Evidence, economics, and ethics. *Public Health Genomics* 2010; 13:106–115.

A growing number of genetic tests require the same kind of scrutiny as screening for common complex diseases, such as breast, cervical, and colorectal cancer. However, there is a dearth of high-quality evidence from randomized trials for genetic disorders. Implications of genetic information as related to privacy and autonomy raise a variety of ethical, legal, and social issues. Settings for genetic screening are most commonly the reproductive setting, both before conception and in the prenatal period, as well as in the newborn and even adults. Some genetic screening, such as for phenylketonuria, has become virtually universal in industrialized nations, but screening for cystic fibrosis or hemoglobinopathies has been more variable. There is also screening available for adults for mutations associated with late-onset diseases, such as hereditary hemochromatosis, familial hypercholesterolemia, and familial cancers.

Criteria for population screening for genetic disorders began with the 1968 publication of the Wilson and Jugner criteria by the World Health Organization and, since then, dozens of lists of criteria have been developed. Criteria include such items as magnitude of the health problem, the availability of effective therapies that substantially alter the course of the disease, the expected benefits and harms from early detection and treatment during the latent period, and the perceived validity and acceptability of the tests. Cost is a consideration, but there is no consensus on how to balance cost and health benefits. Recently, attention has been focused on additional criteria, such as the overall quality of the screening program, informed choice in equity and access, and the general acceptability of the screening tests.

The authors review current evidence-based processes used in the United States, the United Kingdom, and The Netherlands to assess genetic screening programs, specifically addressing critical evidentiary, economic, and ethical issues that arise in the appraisal of screening tests offered to the population. Tandem mass spectrometry is a new technology that can be used to screen for dozens of inborn errors of metabolism, but there has been little agreement among countries as to which specific disorders should be included in the screening panels. In the United States, the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, the Evaluation of Genomic Applications for Practice and Prevention working group, and the American College of Medical Genetics have all been actively involved in making recommendations for genetic screening. One result was that the American College of Medical Genetics' core panel of 29 disorders was endorsed, and, by the end of 2008, 21 of the 29 disorders had been incorporated by

all 50 states for genetic screening for newborns.

The authors review different approaches to consider cost effectiveness, yet considerations about cost effectiveness seem to have had little impact on the adoption of genetic screening tests. The authors also consider ethical challenges in genetic screening, which include issues related to informed consent, for instance, how to deal with informed consent in the context of newborn screening. Virtually all U.S. programs require infants be screened but do not require parental consent or even awareness. Most U.S. states allow parents to request that newborn genetic screening not be done in certain circumstances, but this fact is generally not known. Ethicists have questioned the justification for mandatory screening and have called for informed participation by parents. In The Netherlands, newborn genetic screening has been voluntary, and, in France, laws require written consent for genetic screening, although by the end of the first year of screening for cystic fibrosis in France, 99.8% of parents had given written consent. The authors also argue that having a balance between the expected benefits for individuals and the potential harms is a critical ethical question for any population genetic screening program. False-positive results can cause needless anxiety and lead to unnecessary treatments, but if the benefits resulting from early identification are dramatic with good evidence, they can outweigh such concerns. The authors also review ethical problems associated with ethnically targeted screening, such as newborn screening for sickle cell disease. Another ethical challenge the authors discuss is when individuals are identified as carriers of autosomal recessive genes for disorders. Policies vary regarding the reporting of such autosomal recessive traits. Newborn screening programs in the United States may disclose carrier information but without consistency or the provision of genetic counseling. The authors note that technological capability, advocacy, and medical opinion have largely shaped genetic screening policies and argue for a more rigorous approach that considers a variety of ethical issues, as well as cost effectiveness. *The authors conclude that in addition to scientific evidence, the view of ethicists, economists, healthcare payers, and the public should be included in policy development regarding genetic screening.*

These Abstracts of Note were written by Aimee Kaempf, Ken Iserson, and Barry Morenz.