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.

Ubel PA, Arnold RM, Gramelspacher GP, et al. Acceptance of external funds by physician organizations: issues and policy options. *Journal of General Internal Medicine* 1995;10(11):624–30.

Conflict of interest issues have been raised by many national physician organizations in the United States (and have been largely ignored by practicing physicians). Groups controlling continuing medical education (CME) have raised such issues concerning sponsorship of CME programs, and received a somewhat better response, since they have "a big stick" with which to enforce their policies. Now a group of physician-ethicists are themselves addressing the issues of how and when organizations should accept external sponsorship for educational programs.

The authors first recognize that there are potential benefits to accepting external funds. These funds can certainly enhance organizational activities and improve relationships between the organization and the funding sources. Whether such a relationship is beneficial depends on the funding source. They also state that accepting these funds provides "organization members with an example of health industry relations." They state that these organizations can act as "role models" for their members, and recognize that they often do—as negative role models.

Organizations taking these funds may compromise their own credibility and encourage individual practitioners to ignore rules governing their interaction with drug and medical manufacturing companies. In addition, they may become dependent on these funds, as the example case implies; create "distributive injustice" when these sources pass on the cost of their largesse to patients; and overwhelm the views of those members who feel that this violates their own professional ethical standards.

The authors suggest several policy options available to medical organizations. First, they can accept no external funds. While implementing such a policy is difficult, they give examples of some instances where organizations have succeeded in doing this, including the Society of General Internal Medicine. Second, societies can accept funds based on the external source's involvement in patient care (accept funds only from those not promoting healthcare products), on the consistency of the source's goals with that of the society, or on the source's profit status. Third, at the risk of decreasing the society's fundraising effectiveness, the authors suggest that a group independent of the society's other activities be charged with generating external funds. Fourth, societies could set a limit on the amount of external funds accepted as a single donation or as a percentage of its budget. They posit that this may lessen the dependence on such funds. Lastly, they suggest limiting contributions based on whether the funds are restricted or unrestricted in the purposes for which they can be used.

While these authors nicely lay out the issues involved and policy options available regarding professional societies accepting outside funding, pressures on physician-organization executives to constantly do more with static or decreasing budgets suggests that no one should hold his, or her, breath waiting for any large medical society to implement any but the most lenient guidelines for their dealings with external funding sources.

Orentlicher D. Paying physicians more to do less: financial incentives to limit care. *Richmond Law Review* 1996;30(1):155-97.

Little more than teeth gnashing and loud wailing have, as yet, gone into the discus-

Cambridge Quarterly of Healthcare Ethics (1997), **6**, 121–123. Printed in the USA.

sion of financial incentives for physicians to limit care. This cogent article suggests that once we abandon a fee-for-service system, the question is not whether there should be financial incentives to limit care, but rather how they should be structured. The author, who recently served as the staff for the AMA's Council on Ethical and Judicial Affairs, points out that even simply putting physicians on straight salary is an incentive to do less. (If anyone needs a good example of this, look at physicians' behavior in socialized medical systems.)

His thesis is that it is the physician who ultimately determines the use of medical resources for each patient. Therefore, to guarantee compliance with cutting costs, he or she should receive a financial incentive to limit these costs. The trick, of course, is to balance three factors: make the incentive high enough so that it influences practitioners' behavior, do not make it so high that each decision makes a significant difference to their incomes, and do not make the entire system so rigid (system rationing) that the physician has no flexibility when treating individual patients.

This article represents the beginning of a rational debate rather than simply the profession's loud screams. It's about time the debate started in earnest.

Beyleveld D, Howells GG, Longley D. Heart valve ownership: legal, ethical and policy issues. *Journal of Heart Value Disease* 1995;4(Suppl. I):S2–S6.

Who owns removed body parts was resolved in the United States, at least in part, with the *Moore* case several years ago. Britain is now wrestling with a somewhat knottier issue: Who owns the rights to dispose of and to test (or to supervise the testing of) implantable medical devices removed from a person or corpse? The specific case these authors address is that of artificial heart valves.

A number of parties have a legitimate claim to ownership, or at least temporary control, of an explanted heart valve. Legally, the claim is resolved based on the merits of various claims. Among the parties involved are the patient (or estate) to see if there was negligence; the manufacturer for quality assurance, product development, and to see if they might be sued; other patients with the same device, who want to know how well it functioned; and official regulators of implantable medical devices. Neither the old British law (Human Tissue Act) nor the new European Community directive (Directive on Medical Devices) is clear on what devices they include, especially in regard to devices that may be biologically based.

The authors conclude that, based on an overriding concern for public welfare, Britain's Medical Devices Agency should be given "custody" of the valve to investigate adverse incidents and to test it. They believe that Britain (and presumably the rest of the EC) needs statutes to govern this, and they are fearful of random judicial decisions that may confuse the issues involved.

The discussion following the article points out that, in the United States, patients are acknowledged to "own" their heart valves, but the hospitals (through the courts) have "custody" for up to five years once the valves are removed. During this time, manufacturers can examine the valves. This separates the issues of custody and ownership. If patients want their valves, they can petition the courts.

Calltorp J. Sweden: no easy choices. *British Medical Bulletin* 1995;51:791–8.

Sweden's healthcare system is based on equity, and in the past, on nearly unlimited benefits. The system is one of the most public in the world, with the county councils' responsibility to provide healthcare closely tied to its right to levy taxes. In 1995 the Swedish National Commission on Priorities in Health Care issued a report officially recognizing for the first time that the welfare state, and specifically its "heart and soul," the healthcare system, has limits. (Both the report, *Priorities in Health Care—Ethics, Economy, Implementation*, and the Commission's 1991 discussion document, *No Easy Choice*, are available in English.)

The politicians and expert advisers who made up the commission arrived at three ethical principles to guide both the political/administrative and the clinical prioritization of health services. Listed in hierarchical order, these principles are: (1) human dignity (equity to individuals), (2) need and solidarity (equity to groups and the disadvantaged), and (3) cost-efficiency (cost-benefit evaluations based on quality of life).

They specifically rejected certain rationing methods used elsewhere in the Western world. These include age-based rationing, size- or weight-based rationing without looking at the clinical picture for premature neonates, and rationing based on the use of self-inflicted injury to deny care. They do recognize, however, that some patients who

continue to willingly contribute to the worsening of their disease states may be denied treatments (such as smoking with severe peripheral vascular disease).

Finally, the commission took the first step toward prioritizing healthcare. At the top of their list are the life-threatening acute diseases that can lead to permanent disability if not treated. These are followed by severe chronic diseases, palliative terminal care, and care of those with reduced autonomy. Next are preventive medical treatments, followed by treatments of less-severe acute and chronic diseases, then borderline cases, and finally care for reasons other than disease or injury (e.g., plastic surgery).

This is the first tenuous and difficult step by a socialized healthcare system trying to come to terms with its limitations. Everyone will watch to see if they succeed in cutting costs while maintaining their standard of healthcare, since everyone else is also in the same situation.

Green MJ, Mitchell G, Stocking CB, et al. Do actions reported by physicians in training conflict with consensus guidelines on ethics? *Archives of Internal Medicine* 1996;156: 298–304.

National societies of health professionals routinely issue ethical guidelines. The question is, does anyone listen? And if they do, do they abide by these guidelines? These authors evaluated one of the most widely known of these documents: the American College of Physicians' *Ethics Manual*, published in 1992. They randomly surveyed 1,000 internal medicine residents who belonged to the College to determine whether they knew the rules set out in the *Manual*, and whether they followed these rules even if they did not know that their College had published them.

They found that of the 40% of those surveyed who returned the questionnaires, nearly all had acted in a manner contrary to one or more of the guidelines. Categorized by general ethical principles, 26% of the respondents acted contrary to the guidelines on confidentiality and consent, 20% acted contrary to those on truth telling and disclosure, 19% acted contrary to those on respecting patients' wishes, 14% acted contrary to those on conflicts of interest, and 16% acted contrary to those governing conflicts between residents and attending physicians.

The specific guidelines that residents violated most often were intentionally not telling patients of their inexperience in performing a procedure (62%), acting as their own physician (46%), providing acute medical treatment to their close friends (45%) or family (43%), releasing patient information without explicit patient consent (45%), lying to an attending physician about something they neglected to do or check (37%), and not telling a patient that a student would perform a procedure (35%).

The respondents said that they were aware of the guidelines when they violated them, but the situation did not represent an ethical dilemma to them (30%), they were not able to act in accordance with the guidelines (29%), or they believed that other ethical guidelines overrode the one they violated (21%). Seventeen percent were not aware of the ethical guideline at the time they violated it.

Now that this study has demonstrated that many of our housestaff act in a manner the profession considers unethical, the question arises: what will we do? Do we simply provide better education in the guidelines applicable to different groups of health professionals during training? Or is it, rather, a deeper problem that stems from modeling unacceptable behavior on the parts of some of their senior residents and teachers? In any event, this paper presents a very troubling picture—and this does not bode well for the next generation of physicians.