



# MEDICINE

## *AMA OK—for Today*

It is not every day that the American Medical Association updates its *Code of Medical Ethics*. It has been more than fifty years since they revised it. The latest edition was summarized in the September 13, 2016, issue of *JAMA*, which includes the AMA's core principles of medical ethics and a web link to the more expansive code.<sup>1</sup>

It would seem that bioethical principles, if both ethical and principled, would not warrant much change. Catholic bioethics does not. What does change are the technologies, medications, situations, and culture to which they are applied. The good news is that the AMA code seems to have generally survived what could have been the ravages of modernism, utilitarianism and moral relativism. It remains relatively traditional for something that has been modernized.

Unlike much current secular bioethics, it reasserts the moral agency of the physician and upholds key principles that are relevant to the current debate on conscience rights. For example, "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."<sup>2</sup> While the emergency exception clause could become a loophole, the right of free association could serve as a meaningful bulwark against coercion.

The code consists of eleven chapters and thirty-three topics. Of particular note, it adamantly opposes physician-assisted suicide and euthanasia. As for abortion, it only says, "The Principles of Medical Ethics of the AMA do not prohibit a physician

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1. Stephen Brotherton, Audiey Kao, and B.J. Crigger, "Professing the Values of Medicine: The Modernized AMA *Code of Medical Ethics*," *JAMA* 316.10 (September 13, 2016): 1041–1042, doi: 10.1001/jama.2016.9752; and "Medical Ethics," American Medical Association (AMA), accessed March 9, 2017, <https://www.ama-assn.org/>.

2. AMA, *Code of Medical Ethics*, Principles of Medical Ethics (revised June 2001), n. 6.

from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.”<sup>3</sup> Given our current culture, a secular medical group that allows but does not endorse abortion is about as much as we can hope for. Time will tell whether it will last.

### *Bioethics in Jackboots*

If the revised *Code of Medical Ethics* is better than expected, a distressing article in *Bioethics* typifies the current mindset of secular bioethicists. “Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception” is not a minority report.<sup>4</sup> Its authors, Julian Savulescu and Udo Schuklenk, are prominent bioethics department chairs and the editors of two of the best-known bioethical journals, *Journal of Bioethics* and *Bioethics*, respectively. Written in response to a *Bioethics* piece supporting physician conscience rights,<sup>5</sup> their work is shockingly forthright in its anti-Catholicism, cynicism, and nihilism.

The authors posit that medical conscientious objection is but an ill-begotten relic of organized religion’s undue influence in society, specifically that of Catholicism. They brand conscience objectors treatment deniers, with all the historical and rhetorical baggage that “denial” implies, and explicitly call for banning the faithful from any kind of medical employment for the apparent crime of being unwilling to kill. They call for “medical ethics education to encourage better understanding of values,” except, of course, religious ones. They propose restricting physicians’ moral agency to dialoguing with patients and shaping policy and law, excluding them from any substantive role in the clinical decision-making process.

Savulescu and Schuklenk misleadingly argue against ethical relativism and nihilism but end up wallowing in both. They invoke Nazi justifications for the Holocaust as an example of ethical relativism but offer absolutely nothing with which to counter it. Without an ethical framework, everything is irredeemably relative. The authors contend, “The scope of medical practice is ultimately determined by society, and that it is bound to evolve over time.” Indeed, it seems we are living through a period of rapid devolution in bioethics, in large part because of beliefs like this. The authors knowingly advocate that bioethics should be merely a rough consensus of majority preferences, which explicitly excludes religious values. If that is the case, they might as well shutter their bioethics departments and journals and replace them with a Twitter feed. Before persisting in their belief that organized religion is deadly, they might check organized atheism’s death toll during the last century. Mentions of Nazism, the Holocaust and treatment deniers in a paper essentially arguing for compelled cooperation in the taking of life: no wonder it reads like bioethics in jackboots.

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3. Ibid., Options on Genetics and Reproductive Medicine, 4.2.7.

4. Julian Savulescu and Udo Schuklenk, “Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception,” *Bioethics* 31.3 (March 2017): 162–170, doi: 10.1111/bioe.12288.

5. Christopher Cowley, “A Defence of Conscientious Objection in Medicine: A Reply to Schuklenk and Savulescu,” *Bioethics* 30.5 (June 2016): 358–364, doi: 10.1111/bioe.12233.

*Medicine vs. Human Trafficking*

Wendy Macias-Konstantopoulos's article in *Annals of Internal Medicine* examines physicians' role in combatting human trafficking.<sup>6</sup> The catalog of suffering compiled from earlier studies makes for depressing reading: In 2012, an estimated 20 million persons worldwide were victims of trafficking—55 percent women, 26 percent children. “90% of sex-trafficked children develop substance abuse disorders, 12% have forced abortions and 16% attempt suicide.” Voluntary disclosure is rare, and many victims are missed despite presentation for medical care while being trafficked. The author lists some neglected indicators of human trafficking, including the physically grotesque (foreign bodies to stop menstrual flow and tattoos or branding indicating ownership), the psychological (accompaniment by a person who insists on translating), and the subtle (clothing that is inappropriate for the weather). Health care teams that identify victims still face barriers, for which the author proposes a useful “framework for the development of human trafficking response protocols.”

Human trafficking remains a concern of the Church. Pope Francis has called it a scourge and instituted an International Day of Prayer and Awareness against Human Trafficking in 2015. That day is marked annually and appropriately on February 8, the feast of St. Josephine Bakita (d. 1947), a Sudanese slave who eventually became a Canossian Sister in Italy.

*By Their Own Young Hands*

In *Pediatrics*, “Suicide in Elementary School-Aged Children and Early Adolescents,” a title that is itself a sad commentary, reports on the epidemiology of childhood suicide.<sup>7</sup> Analyzing the National Violent Death Reporting System data from seventeen states for 2003 to 2012, the authors found 693 deaths among children aged five to fourteen years. The study, published in examined differences between decedents in cohorts comprising five- to eleven-year-olds and twelve- to fourteen-year-olds. Child suicides occurred more commonly among black males who suffocated at home by hanging or strangling. Relationship problems did not differ by race and were far more common among family members and friends than between boyfriends and girlfriends. Fewer children left suicide notes (8 vs. 30 percent) and more had attention-deficit disorder (59 percent) than the depression/dysthymia seen more commonly in adolescents (66 percent). Twenty-nine percent of both groups disclosed suicidal intent prior to their deaths.

The authors suggest that there may be a “developmental progression of vulnerability to suicide . . . that is more prominently influenced by impulsive responding in younger children and by depressed mood and emotional distress” in older youth. So universal suicide prevention strategies may be inadequate, and younger children

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6. Wendy Macias-Konstantopoulos, “Human Trafficking: The Role of Medicine in Interrupting the Cycle of Violence and Abuse,” *Annals of Internal Medicine* 165.8 (October 18, 2016): 582–588, doi: 10.7326/M16-0094.

7. Arielle H. Sheftall et al., “Suicide in Elementary School-Aged Children and Early Adolescents,” *Pediatrics* 138.4 (October 2016): 1–7, doi: 10.1542/peds.2016-0436.

may benefit from a different, targeted approach. Both tasks will be decidedly more difficult in a society that is increasingly normalizing physician-assisted and other forms of suicide in adults.

*Liberty, Need, and Serious Mental Illness*

The challenges of caring for the seriously mentally ill are discussed in Lisa Rosenbaum's intriguing "Liberty versus Need: Our Struggle to Care for People with Serious Mental Illness," published in the October 13, 2016, issue of the *New England Journal of Medicine*.<sup>8</sup> The statistics she presents are sobering. One quarter of homeless people in the United States have serious mental illness. The average gap between the onset and treatment of major depressive disorders is eight years. There are now only 11.7 psychiatric beds per hundred thousand population, compared with 337 per hundred thousand in 1955. Mental illness, often in combination with neurologic or substance abuse, results in more years lived with disability than any other illness.

Rosenbaum identifies two key causes of under-treatment: the unpleasant and often serious side effects of antipsychotic medications, and anosognosia—patients' belief that they do not have a condition that warrants treatment. However, some of the challenges may be due, in part, to the well-intentioned misapplication of bioethical principles. Rosenbaum posits that an autonomy-preserving spirit may leave severe mental illness untreated out of an oversized fear of stigmatization that can mask the gravity of disease. In addition, the systemic embrace of the principles of the recovery movement, which holds that everyone with mental illness can recover, may become antagonistic to and a subtle rebuke to psychiatrists "who are perceived as having acted solely out of self-interest in insisting that people with serious mental illness have a lifelong need for psychiatric care." The recovery model may result in a "self-serving tautology: if you value self-determination and therefore defer to the patient's choice, success is guaranteed, because success is defined as self-determination."

While the age of unbridled medical paternalism has surely and rightfully passed, Rosenbaum favorably mentions a limited form called the thank-you theory of paternalistic intervention. Promulgated by Alan Stone, a Harvard physician and lawyer in the 1970s, it argues that "when someone with serious mental illness declines treatment, need ought to trump liberty if, once psychiatrically stabilized, the person was likely to be grateful for the intervention." Another approach she mentions are Ulysses grants, "whereby people sign agreements when they're relatively well to receive psychiatric treatment when they have a psychiatric episode, overriding any future refusal of care." Both are promising but might be tough sells in our current age that values autonomy as the first principle of bioethics.

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8. Lisa Rosenbaum, "Liberty versus Need: Our Struggle to Care for People with Serious Mental Illness," *New England Journal of Medicine* 375.15 (October 13, 2016):1490–1495, doi: 10.1056/NEJMms1610124.

*The Quandary of Mercy*

The causes of and remedies for the increasing opioid epidemic are topics of much current interest. Most research has focused on supply, mainly the greater availability of prescription and illicit opioids. In the *Annals of Internal Medicine*, Nicholas King et al. focus on an aspect of demand in their paper titled, “Has the Increased in Disability Insurance Participation Contributed to Increased Opioid-Related Mortality?”<sup>9</sup>

First, the numbers: More than fifty-two thousand drug-related deaths occurred in 2015. Over 60 percent were due to opioids, a fourfold increase since 1999. While the number of disabled workers in the United States has been rising since 1980, it has doubled since 1995. The largest increase has been in claims for back and other musculoskeletal pain, despite their general incidence remaining flat. Half of disabled Medicare beneficiaries under age sixty-five use opioids in a given year, and the numbers of long-term users, multiple prescribers, and individuals with one or more nonfatal overdoses have all significantly increased.

The authors suggest that bipartisan welfare reform enacted in 1996, which included stricter eligibility and benefit time limits, may have led to more widespread participation in federal disability benefits programs, increasing both demand for and access to opioid analgesics and provoking a subsequent rise in opioid-related mortality. The authors contend that this “may have provided an incentive for states to encourage people to enroll in disability-related assistance programs,” effectively medicalizing social support. This, in turn, “created new avenues of access to and potential demand for opioid analgesic as people were incentivized to seek a diagnosis of severe impairment for musculoskeletal pain.” They point out that not all the carnage falls on disability recipients, though it falls close by, as prescribed opioids are often diverted to friends and family members.

In contrast to the authors’ conclusion, previous data has linked that same welfare reform to a 10 percent decline in single-family childhood poverty, partially explaining a childhood poverty rate that is now at an all-time low. They also do not address the role of federal disability insurance in the dramatic decrease in the workforce participation rate, especially among working-age males, and its attendant social costs.

King et al. call for “further research into the possible effect of changes in social insurance policies on the demand for and availability of prescription opioids.” Such research is certainly warranted: welfare, disability insurance, and Medicaid drug benefits are all well-intentioned, life-saving resources for many and would seem to be justified by the bioethical principles of justice and beneficence. However, any policy changes must recognize that even such well-intentioned programs can have significant unintended adverse outcomes. It can be argued that, in this context, such programs can also lead to maleficence and impede autonomy. To paraphrase St. Bernard of Clairvaux, the road to hell is paved with very good intentions. Such is the occasional quandary of mercy.

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9. N.B. King, E. Strumpf, and S. Harper, “Has the Increase in Disability Insurance Participation Contributed to Increased Opioid-Related Mortality?,” *Annals of Internal Medicine* 165.10 (November 15, 2016): 729–730, doi: 10.7326/M16-0918.

*Waste Not a Serious Crisis*

While the transmission rate of Zika virus appears to be waning, rationales for our unrestricted abortion license are ever waxing. In “Zika as a Catalyst for Social Change,” published in *Pediatrics* online, Joia Brosco and Jeffrey Brosco argue that, as the 1963–1965 US rubella epidemic and subsequent fetal malformations contributed to pre-*Roe v. Wade* liberalization of state abortion laws, today’s Zika epidemic “may provide the urgency and biological legitimacy to those seeking to reduce the stigma and eliminate legal barriers to birth control and abortion.”<sup>10</sup> The authors address the situation in the United States and overseas, especially in Latin America and the Caribbean. They lament that “97% of young women live in countries where access to safe abortion is severely restricted by law,” and “legal, cultural and religious beliefs restrict access in a region where 88% of the people identify with Catholic or Protestant beliefs.” They note favorably that the United Nations High Commissioner for (Born) Human Rights has called on Latin American nations to repeal policies that break with international standards, which, loosely translates to “the unrelentingly pro-abortion policy preferences of post-Christian, Western elites.” Apparently, abortion trumps even multiculturalism these days.

The author’s logic follows a bad news/good news setup: unfortunately, a new virus out there can cause fetal malformations, but it provides an awesome justification for expanding our already nearly unlimited abortion license. To add insult to injury, it appears in a respected pediatric journal, which never seems to grasp the irony of routinely trumpeting incrementally decreasing child mortality rates while ignoring, countenancing, or even endorsing the deaths of tens of millions of unborn children.

*No Infant Simulators, Especially for Catholics*

A research study in *Lancet* examined the efficacy of teenage pregnancy-prevention programs that use infant simulators.<sup>11</sup> In an interesting methodological exception, “all 66 government and non-government high schools (*excluding Catholic schools*) in the Perth metropolitan area of Western Australia were invited to participate” (emphases added). “All” apparently does not include Catholics. Try to purposefully exclude any other religious group from a proposed study and see what your friendly institutional review board has to say about that. Perhaps it is a backhanded compliment.

The researchers compared girls aged thirteen to fifteen years in a virtual infant parenting (VIP) program, which included an infant simulator replicating sleeping and feeding, to those who received a standard health education curriculum. Study subjects were followed to age twenty. The low participation rates (50 to 58 percent) at both the intervention and control schools might have skewed the results.

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10. Joia Hordett Brosco and Jeffrey P. Brosco, “Zika as a Catalyst for Social Change,” *Pediatrics* 138.6, e-pub December 1, 2016, e20162095: 1–2, doi: 10.1542.peds.2016-2095.

11. Sally A. Brinkman et al., “Efficacy of Infant Simulator Programmes to Prevent Teenage Pregnancy: A School-Based Cluster Randomised Controlled Trial in Western Australia,” *Lancet* 388.10057 (November 5, 2016): 2264–2271, doi: 10/1016/50140-6736(16)30384-1.



The researchers found that a higher proportion of girls in the VIP group reported more births (8 vs. 4 percent) or at least one abortion as the first pregnancy event (9 vs. 6 percent). The abortion proportion—a term I had not previously encountered—for teen girls in the study was similar (57 percent) to that of Western Australian teens as a whole (52 percent). The authors therefore suggest that such programs “are likely to be an ineffective use of public resources aimed at teenage pregnancy prevention.”

In an accompanying editorial, Julie Quinlivan (like one of the study’s authors, from the University of Notre Dame Australia) posits four reasons why the magic dolls did not work: (1) Boys were not involved, and the boys most likely to father a child would also be most likely to refuse the program. (2) Teenage pregnancy is an outcome, not a cause, of adversity. (3) Teenage girls who become parents idealize parenthood, and the brief exposure to a doll reinforces that idealization. (4) It is likely that teen pregnancy has a more associative causal relationship with social and economic burdens.<sup>12</sup>

The point about boys is well taken. Yes, idealizing young parenthood can be problematic, but it probably beats cynicism if we want older yet still young families to form and thrive. In addition, considerable data suggest that teen pregnancy is a major cause of future socioeconomic disadvantage. Nearly everyone agrees that reducing the teen pregnancy rate is a good thing, but people hold different opinions on both how best to accomplish this goal and whether success should be measured from a practical or an ethical point of view. Nearly everyone used to agree that reducing the teenage abortion rate is a good thing, though the recently renewed stridency of the pro-abortion movement has called that into question. When we expect government or public solutions to solve essentially personal issues, we are bound to be disappointed. By definition, such solutions are value-free or incorporate values that are actively hostile to people of faith. In this study, such solutions proved ineffective. Lastly, would it be too much to expect studies and editorials from avowedly Catholic universities to test or espouse Catholic solutions and values? It is disappointing to know, at present, it probably is.

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12. Julie A. Quinlivan, “Magic Dolls: No Quick Fix for Teenage Pregnancy,” *Lancet* 388.10057 (November 5, 2016): 2214–2215, doi: 10/1016/50140-6736(16)31411-8.

## MEDICINE ABSTRACTS

### *American Journal of Public Health*

**Goleen Samari, Islamophobia and public health in the United States**, *Am J Public Health* 106.11 (November 2016): 1920–1925, doi:10.1205/AJPH.2016.303374 • Anti-Muslim sentiments are increasingly common globally and in the United States. The recent rise in Islamophobia calls for a public health perspective that considers the stigmatized identity of Muslim Americans and health implications of Islamophobic discrimination. Drawing on a stigma, discrimination, and health framework, I expand the dialogue on the rise of Islamophobia to a discussion of how Islamophobia affects the health of Muslim Americans. Islamophobia can negatively influence health by disrupting several systems-- individual (stress reactivity and identity concealment), interpersonal (social relationships and socialization processes), and structural (institutional policies and media coverage). Islamophobia deserves attention as a source of negative health outcomes and health disparities. Future public health research should explore the multilevel and multidimensional pathways between Islamophobia and population health.

### *Annals of Internal Medicine*

**Wendy Macias-Konstantopoulos, Human trafficking: the role of medicine in interrupting the cycle of abuse and violence**, *Ann Intern Med* 165.8 (October 18, 2016): 582–588, doi:10.7326/M16-0094 • Human trafficking, a form of modern slavery, is an egregious violation of human rights with profound personal and public health implications. It includes forced labor and sexual exploitation of both U.S. and non-U.S. citizens and has been reported in all 50 states. Victims of human trafficking are currently among the most abused and disenfranchised persons in society, and they face a wide range

of negative health outcomes resulting from their subjugation and exploitation. Medicine has an important role to play in mitigating the devastating effects of human trafficking on individuals and society. Victims are cared for in emergency departments, primary care offices, urgent care centers, community health clinics, and reproductive health clinics. In addition, they are unknowingly being treated in hospital inpatient units. Injuries and illnesses requiring medical attention thus represent unique windows of opportunity for trafficked persons to receive assistance from trusted health care professionals. With education and training, health care providers can recognize signs and symptoms of trafficking, provide trauma-informed care to this vulnerable population, and respond to exploited persons who are interested and ready to receive assistance. Multidisciplinary response protocols, research, and policy advocacy can enhance the impact of anti-trafficking health care efforts to interrupt the cycle of abuse and violence for these victims.

### *Bioethics*

**Julian Savulescu and Udo Schuklenk, Doctors have no right to refuse medical assistance in dying, abortion or contraception**, *Bioethics* 31.3 (March 2017): 162–170, doi: 10.1111/bioe.12288 • In an article in this journal, Christopher Cowley argues that we have “misunderstood the special nature of medicine, and have misunderstood the motivations of the conscientious objectors.” We have not. It is Cowley who has misunderstood the role of personal values in the profession of medicine. We argue that there should be better protections for patients from doctors’ personal values and there should be more severe restrictions on the right to conscientious objection, particularly in relation to assisted dying. We argue that eligible patients could be guaranteed access to



medical services that are subject to conscientious objections by: (1) removing a right to conscientious objection; (2) selecting candidates into relevant medical specialties or general practice who do not have objections; (3) de-monopolizing the provision of these services away from the medical profession.

### JAMA

*Dio Kavalieratos et al., Association between palliative care and patient and caregiver outcomes: a systematic review and meta-analysis, JAMA 316.20 (November 22, 2016): 2104–2114, doi:10.1001/jama.2016.16840 • Importance:* The use of palliative care programs and the number of trials assessing their effectiveness have increased. *Objective:* To determine the association of palliative care with quality of life (QOL), symptom burden, survival, and other outcomes for people with life-limiting illness and for their caregivers. *Data Sources:* MEDLINE, EMBASE, CINAHL, and Cochrane CENTRAL to July 2016. *Study Selection:* Randomized clinical trials of palliative care interventions in adults with life-limiting illness. *Data Extraction and Synthesis:* Two reviewers independently extracted data. Narrative synthesis was conducted for all trials. Quality of life, symptom burden, and survival were analyzed using random-effects meta-analysis, with estimates of QOL translated to units of the Functional Assessment of Chronic Illness Therapy-palliative care scale (FACIT-Pal) instrument (range, 0–184 [worst-best]; minimal clinically important difference [MCID], 9 points); and symptom burden translated to the Edmonton Symptom Assessment Scale (ESAS) (range, 0–90 [best-worst]; MCID, 5.7 points). *Main Outcomes and Measures:* Quality of life, symptom burden, survival, mood, advance care planning, site of death, health care satisfaction, resource utilization, and health care expenditures. *Results:* Forty-three RCTs provided data on 12,731 patients (mean age, 67 years) and 2,479 caregivers. Thirty-five trials used usual care as the control, and 14 took place in the ambulatory setting. In the meta-analysis, palliative care was associated with statistically and clinically significant improvements in

patient QOL at the 1- to 3-month follow-up (standardized mean difference, 0.46; 95% CI, 0.08 to 0.83; FACIT-Pal mean difference, 11.36) and symptom burden at the 1- to 3-month follow-up (standardized mean difference, -0.66; 95% CI, -1.25 to -0.07; ESAS mean difference, -10.30). When analyses were limited to trials at low risk of bias ( $n = 5$ ), the association between palliative care and QOL was attenuated but remained statistically significant (standardized mean difference, 0.20; 95% CI, 0.06 to 0.34; FACIT-Pal mean difference, 4.94), whereas the association with symptom burden was not statistically significant (standardized mean difference, -0.21; 95% CI, -0.42 to 0.00; ESAS mean difference, -3.28). There was no association between palliative care and survival (hazard ratio, 0.90; 95% CI, 0.69 to 1.17). Palliative care was associated consistently with improvements in advance care planning, patient and caregiver satisfaction, and lower health care utilization. Evidence of associations with other outcomes was mixed. *Conclusions and Relevance:* In this meta-analysis, palliative care interventions were associated with improvements in patient QOL and symptom burden. Findings for caregiver outcomes were inconsistent. However, many associations were no longer significant when limited to trials at low risk of bias, and there was no significant association between palliative care and survival.

### JAMA Internal Medicine

*Gilbert Gonzales et al., Comparison of health and health risk factors between lesbian, gay, and bisexual adults and heterosexual adults in the United States: results from the national health interview survey, JAMA Intern Med 176.9 (September 1, 2016): 1344–1351, doi:10.1001/jamainternmed.2016.3432 • Importance:* Previous studies identified disparities in health and health risk factors among lesbian, gay, and bisexual (LGB) adults, but prior investigations have been confined to samples not representative of the US adult population or have been limited in size or geographic scope. For the first time in its long history, the 2013 and 2014 National Health Interview

Survey included a question on sexual orientation, providing health information on sexual minorities from one of the nation's leading health surveys. *Objective:* To compare health and health risk factors between LGB adults and heterosexual adults in the United States. *Design, Setting, and Participants:* Data from the nationally representative 2013 and 2014 National Health Interview Survey were used to compare health outcomes among lesbian (n = 525), gay (n = 624), and bisexual (n = 515) adults who were 18 years or older and their heterosexual peers (n = 67,150) using logistic regression. *Main Outcomes and Measures:* Self-rated health, functional status, chronic conditions, psychological distress, alcohol consumption, and cigarette use. *Results:* The study cohort comprised 68,814 participants. Their mean (SD) age was 46.8 (11.8) years, and 51.8% (38,063 of 68,814) were female. After controlling for sociodemographic characteristics, gay men were more likely to report severe psychological distress (odds ratio [OR], 2.82; 95% CI, 1.55–5.14), heavy drinking (OR, 1.97; 95% CI, 1.08–3.58), and moderate smoking (OR, 1.98; 95% CI, 1.39–2.81) than heterosexual men; bisexual men were more likely to report severe psychological distress (OR, 4.70; 95% CI, 1.77–12.52), heavy drinking (OR, 3.15; 95% CI, 1.22–8.16), and heavy smoking (OR, 2.10; 95% CI, 1.08–4.10) than heterosexual men; lesbian women were more likely to report moderate psychological distress (OR, 1.34; 95% CI, 1.02–1.76), poor or fair health (OR, 1.91; 95% CI, 1.24–2.95), multiple chronic conditions (OR, 1.58; 95% CI, 1.12–2.22), heavy drinking (OR, 2.63; 95% CI, 1.54–4.50), and heavy smoking (OR, 2.29; 95% CI, 1.36–3.88) than heterosexual women; and bisexual women were more likely to report multiple chronic conditions (OR, 2.07; 95% CI, 1.34–3.20), severe psychological distress (OR, 3.69; 95% CI, 2.19–6.22), heavy drinking (OR, 2.07; 95% CI, 1.20–3.59), and moderate smoking (OR, 1.60; 95% CI, 1.05–2.44) than heterosexual women. *Conclusions and Relevance:* This study supports prior research finding substantial health disparities for LGB adults in the United States, potentially due to the stressors

that LGB people experience as a result of interpersonal and structural discrimination. In screening for health issues, clinicians should be sensitive to the needs of sexual minority patients.

**Lisa Harnack et al., Effects of subsidies and prohibitions on nutrition in a food benefit program: a randomized clinical trial, *JAMA Intern Med* 176.11 (November 2016): 1610–1619, doi:10.1001/jamainternmed.2016.5633 • Importance:**

Strategies to improve the nutritional status of those participating in the Supplemental Nutrition Assistance Program (SNAP) are of interest to policymakers. *Objective:* To evaluate whether the proposed policy of incentivizing the purchase of fruits and vegetables and prohibiting the purchase of less nutritious foods in a food benefit program improves the nutritional quality of participants' diets.

*Design, Setting, and Participants:* Lower income participants (n = 279) not currently enrolled in SNAP were randomized to 1 of 4 experimental financial food benefit conditions: (1) incentive (30% financial incentive for fruits and vegetables purchased using food benefits); (2) restriction (not allowed to buy sugar sweetened beverages, sweet baked goods, or candies with food benefits); (3) incentive plus restriction (30% financial incentive on fruits and vegetables and restriction of purchase of sugar sweetened beverages, sweet baked goods, or candy with food benefits); or (4) control (no incentive or restrictions on foods purchased with food benefits). Participants in all conditions were given a study-specific debit card where funds were added every 4 weeks for a 12-week period. Outcome measures were collected at baseline and in the final 4 weeks of the experimental period. *Main Outcomes and Measures:* Primary outcomes (from 24-hour dietary recalls) included intake of energy, discretionary calories, and overall diet quality. *Results:* A number of favorable changes were observed in the incentive plus restriction condition that were significantly different from changes in the control condition. These included (1) reduced intake of energy (-96 kcal/d, standard error [SE],

59.9); (2) reduced intake of discretionary calories (-64 kcal/d, SE 26.3); (3) reduced intake of sugar sweetened beverages, sweet baked goods, and candies (-0.6 servings/d, SE 0.2); (4) increased intake of solid fruit (0.2 servings/d, SE 0.1); and (5) improved Healthy Eating Index score (4.1 points, SE 1.4). Fewer improvements were observed in the incentive only and restriction only arms. *Conclusions and Relevance:* A food benefit program that pairs incentives for purchasing more fruits and vegetables with restrictions on the purchase of less nutritious foods may reduce energy intake and improve the nutritional quality of the diet of participants compared with a program that does not include incentives or restrictions.

### *Lancet*

*Sally A. Brinkman et al., Efficacy of infant simulator programmes to prevent teenage pregnancy: a school-based cluster randomised controlled trial in Western Australia, Lancet* 388.10057 (November 5, 2016): 2264–2271, doi: 10.1016/S0140-6736(16)30384-1 • *Background:* Infant simulator-based programmes, which aim to prevent teenage pregnancy, are used in high-income as well as low-income and middle-income countries but, despite growing popularity, no published evidence exists of their long-term effect. The aim of this trial was to investigate the effect of such a programme, the Virtual Infant Parenting (VIP) programme, on pregnancy outcomes of birth and induced abortion in Australia. *Methods:* In this school-based pragmatic cluster randomised controlled trial, eligible schools in Perth, Western Australia, were enrolled and randomised 1:1 to the intervention and control groups. Randomisation using a table of random numbers without blocking, stratification, or matching was done by a researcher who was masked to the identity of the schools. Between 2003 and 2006, the VIP programme was administered to girls aged 13–15 years in the intervention schools, while girls of the same age in the control schools received the standard health education curriculum. Participants were followed until they reached 20 years of age via data linkage to hospital medical

and abortion clinic records. The primary endpoint was the occurrence of pregnancy during the teenage years. Binomial and Cox proportional hazards regression was used to test for differences in pregnancy rates between study groups. *Findings:* 57 (86%) of 66 eligible schools were enrolled into the trial and randomly assigned 1:1 to the intervention (28 schools) or the control group (29 schools). Then, between Feb 1, 2003, and May 31, 2006, 1267 girls in the intervention schools received the VIP programme while 1567 girls in the control schools received the standard health education curriculum. Compared with girls in the control group, a higher proportion of girls in the intervention group recorded at least one birth (97 [8%] of 1267 in the intervention group vs 67 [4%] of 1567 in the control group) or at least one abortion as the first pregnancy event (113 [9%] vs 101 [6%]). After adjustment for potential confounders, the intervention group had a higher overall pregnancy risk than the control group (relative risk 1.36 [95% CI 1.10–1.67],  $p=0.003$ ). Similar results were obtained with the use of proportional hazard models (hazard ratio 1.35 [95% CI 1.10–1.67],  $p=0.016$ ). *Interpretation:* The infant simulator-based VIP programme did not achieve its aim of reducing teenage pregnancy. Girls in the intervention group were more likely to experience a birth or an induced abortion than those in the control group before they reached 20 years of age.

### *Pediatrics*

*J.S. Blumenthal-Barby et al., Should neonatologists give opinions withdrawing life-sustaining treatment, Pediatrics* 138.6 (December 2016): e20162585, doi:10.1542/peds.2016-2585 • An infant has a massive intracranial hemorrhage. She is neurologically devastated and ventilator-dependent. The prognosis for pulmonary or neurologic recovery is bleak. The physicians and parents face a choice: withdraw the ventilator and allow her to die or perform a tracheotomy? The parents cling to hope for recovery. The physician must decide how blunt to be in communicating his own opinions and

recommendations. Should the physician try to give just the facts? Or should he also make a recommendation based on his own values? In this article, experts in neonatology, decision-making, and bioethics discuss this situation and the choice that the physician faces.

*Janet R. Serwint et al., The AAP resilience in the face of grief and loss curriculum, Pediatrics* 138.5 (November 2016): e20160791, doi: 10.1542/peds2016-0791 • A career in pediatrics can bring great joy and satisfaction. It can also be challenging and lead some providers to manifest burnout and depression. A curriculum designed to help pediatric health providers acquire resilience and adaptive skills may be a key element in transforming times of anxiety and grief into rewarding professional experiences. The need for this curriculum was identified by the American Academy of Pediatrics Section on Medical Students, Residents and Fellowship Trainees. A working group of educators developed this curriculum to address the professional attitudes, knowledge, and skills essential to thrive despite the many stressors inevitable in clinical care. Fourteen modules incorporating adult learning theory were developed. The first 2 sections of the curriculum address the knowledge and skills to approach disclosure of life-altering diagnoses, and the second 2 sections focus on the provider's responses to difficult patient care experiences and their needs to develop strategies to maintain their own well-being. This curriculum addresses the intellectual and emotional characteristics patient care medical professionals need to provide high-quality, compassionate care while also addressing active and intentional ways to maintain personal wellness and resilience.

*Arielle H. Sheftall et al., Suicide in elementary school-aged children and early adolescents, Pediatrics* 138.4 (October 2016): e20160436, doi: 10.1542/peds.2016-0436 • *Background and Objectives:* Suicide in elementary school-aged children is not well studied, despite a recent increase in the suicide rate among US black children. The objectives of this study were to describe characteristics and precipitating circumstances of suicide in elementary

school-aged children relative to early adolescent decedents and identify potential within-group racial differences. *Methods:* We analyzed National Violent Death Reporting System (NVDRS) surveillance data capturing suicide deaths from 2003 to 2012 for 17 US states. Participants included all suicide decedents aged 5 to 14 years ( $N = 693$ ). Age group comparisons (5–11 years and 12–14 years) were conducted by using the  $\chi^2$  test or Fisher's exact test, as appropriate. *Results:* Compared with early adolescents who died by suicide, children who died by suicide were more commonly male, black, died by hanging/strangulation/suffocation, and died at home. Children who died by suicide more often experienced relationship problems with family members/friends (60.3% vs 46.0%;  $P = .02$ ) and less often experienced boyfriend/girlfriend problems (0% vs 16.0%;  $P < .001$ ) or left a suicide note (7.7% vs 30.2%;  $P < .001$ ). Among suicide decedents with known mental health problems ( $n = 210$ ), childhood decedents more often experienced attention-deficit disorder with or without hyperactivity (59.3% vs 29.0%;  $P = .002$ ) and less often experienced depression/dysthymia (33.3% vs 65.6%;  $P = .001$ ) compared with early adolescent decedents. *Conclusions:* These findings raise questions about impulsive responding to psychosocial adversity in younger suicide decedents, and they suggest a need for both common and developmentally-specific suicide prevention strategies during the elementary school-aged and early adolescent years. Further research should investigate factors associated with the recent increase in suicide rates among black children.

#### *Philosophy, Ethics, and Humanities in Medicine*

*Osamu Muramoto, Informed consent for the diagnosis of brain death: a conceptual argument, Philos Ethics Humanit Med* 11.1, 8 (October 13, 2016): 1–15, doi: 10.1186/s13010-016-0042-4 • *Background:* This essay provides an ethical and conceptual argument for the use of informed consent prior to the diagnosis of brain death. It is meant to enable the family to make critical end-of-life decisions, particularly withdrawal of life support

system and organ donation, before brain death is diagnosed, as opposed to the current practice of making such decisions after the diagnosis of death. The recent tragic case of a 13-year-old brain-dead patient in California who was maintained on a ventilator for over 2 years illustrates how such a consent would have made a crucial difference. *Methods:* Conceptual, philosophical, and ethical analysis. *Results:* I first consider a conceptual justification for the use of consent for certain non-beneficial and unwanted medical diagnoses. I suggest that the diagnosis of brain death falls into this category for some patients. Because the diagnostic process of brain death lacks the transparency of traditional death determination, has a unique epistemic structure and a complex risk-benefit profile which differs markedly from case to case, and presents conflicts of interest for physicians and society, I argue that pre-diagnostic counseling and informed consent should be part of the diagnostic process. This approach can

be termed as “allow cardiac death,” whose parallel logic with “allow natural death” is discussed. I also discuss potential negative impacts on organ donation and health care cost from this proposal and offer possible mitigation. I show that the pre-diagnostic counseling can improve the possibility for well-thought-out decisions regarding organ donation and terminating life-support system in cases of hopeless prognosis. This approach differs conceptually from the pluralism of the definition of death, such as those in New Jersey and Japan, and it upholds the Uniform Determination of Death Act. *Conclusions:* My intention is not to provide an instant panacea for the ongoing impasse of the brain death debate, but to point to a novel conceptual ground for a more pragmatic, and more patient- and family-centered approach. By enabling the family to consent to or decline the diagnostic process of brain death, but not to choose the definition of death, it upholds the current legal definition of death.