

et al did not have colorectal surgery, whereas all of ours did; the infection rate they report thus was high for their population.

In addition to our study of 300 patients, supplemental oxygen has been shown to halve infection risk in another study with 500 patients.⁵ Additional support for supplemental oxygen is provided by a recent study of 2000 general surgical patients randomized to 70% nitrous oxide or 80% oxygen.⁶ Infection risk was significantly less in the oxygen group, a finding presumably due to the benefits of oxygen, because nitrous oxide does not appear to increase infection risk.⁷

The preponderance of evidence thus indicates that the use of supplemental perioperative oxygen markedly reduces wound infection risk.

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Relations Between Physicians and Attorneys

To the Editor: In their Commentary on the relations between attorneys and physicians, Drs Jacobson and Bloche¹ have provided a perspective from which to evaluate difficulties at the interface of law and medicine. In particular, they argue that the current liability crisis has deepened the antipathy of physicians toward attorneys and the legal system, and that a renewed dialogue emphasizing shared values and patient safety is called for in an effort to formulate effective health policy. However, the authors' analysis of shared values is incomplete, and they promote a unilateral move toward accommodation, without recognizing the fundamental cause of the difficulties.

The professions of medicine and law are rooted in 2 profoundly incompatible ethical constructs. Effective tort law,

by definition and in practice, is based on principles of adversarial ethics. Effective medicine, by teaching and in application, is based on principles of cooperative ethics. Faced with the same set of facts in identical situations, the 2 schools of ethics will often lead to opposite conclusions. The authors touch on this dichotomy when they address different approaches to decision making (eg, adversarial vs scientific methods) but fail to see that the 2 ethical systems are irreconcilable.

They advocate what amounts to a one-way street to improved professional relations. Mention is made of the need to address only medical error, not legal error. Both need attention and efforts at prevention, and both need to be balanced with accountability. Further, they state that both professions are "struggling to preserve their domains." This sounds very much like soliciting cooperation for self-preservation as the forces set in motion through disclosure and enhanced public understanding underscore the inadequacies of both professions.

The health and well-being of the public is the overarching legitimate focus of any effort to improve relations between physicians and attorneys. Solutions to the vicissitudes at the interface of medicine and law require transformational leadership willing to engage in honest and open inquiry into the appropriateness of tort law as a tool for patient compensation and error reduction and the ability to embrace nonadversarial alternatives.

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1. Jacobson PD, Bloche MG. Improving relations between attorneys and physicians. *JAMA*. 2005;294:2083-2085.

To the Editor: In their Commentary, Drs Jacobson and Bloche¹ comprehensively outline the interactions and conflicts between the legal and medical professions in modern American society. They conclude that there is potential for reconciliation between the professions if physicians, who are disgruntled with the legal system primarily because of concerns about their risk of medical malpractice tort liability, will recognize their common interests with lawyers in meeting the regulatory and business demands confronting medical practitioners. They also appeal to the 2 professions to cooperate in "reasoned exploration of important health care delivery and policy issues."

Their proposed mechanism for rapprochement between law and medicine assumes that most physicians reflexively distrust all lawyers. In my experience as a physician and as a lawyer, I have found that not to be the general case. Perhaps because of an ingrained familiarity with specialization, physicians naturally distinguish the roles of medical malpractice plaintiffs' attorneys from other lawyers to whom they willingly entrust their own property transactions, estate planning, and other business affairs. Most physicians

recognize lawyers' roles in preparing advance directives for patients. Many refer their patients to lawyers for assistance with Social Security disability claims and recognize that their medical societies would be less effective without lawyers to draft and lobby for proposed regulations and statutes affecting the practice of medicine.

A more important flaw in the authors' analysis is that their proposed path toward reconciliation involves no interaction between physicians and that segment of the bar with which they are in conflict—plaintiffs' attorneys, or "trial lawyers." They offer no solutions for addressing tort reform. Physician involvement in patient safety organizations (pursuant to the Patient Safety and Quality Improvement Act²) could eventually improve patient care and solidify physicians' involvement in systematic quality improvement; however, that statute provides no alternatives to traditional civil litigation for resolving disputes about alleged medical malpractice.

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1. Jacobson PD, Bloche MG. Improving relations between attorneys and physicians. *JAMA*. 2005;294:2083-2085.
2. Pub L No. 109-41, 119 Stat 424 (2005).

To the Editor: Lawyers and physicians will undoubtedly agree that cooperation broadens the skill set available to solve difficult problems. Groups that are at loggerheads in some spheres can work together to achieve shared goals.¹ Unfortunately, when Drs Jacobson and Bloche² move from praising cooperation to providing evidence that cooperation between lawyers and physicians could lead to meaningful tort reform, they grasp at straws.

While physicians and lawyers commonly and productively cooperate outside the domain of malpractice litigation, this is irrelevant to reforming malpractice litigation, where trial lawyers and physicians have fundamentally incompatible views. One group sees "tort reform" where the other sees a threat to "civil rights" and to "your very livelihood."^{3,4}

In 1959, C.P. Snow noted that despite numerous similarities, physical scientists and "literary intellectuals" at Cambridge University functioned as members of different cultures with different world views.⁵ The barriers that separate trial lawyers and physicians are much more extreme than anything that Snow noted in the faculty dining room at Cambridge. This is tragic because reducing medical error is a very difficult task, and trial lawyers and judges would seem to be physicians' natural partners in this effort. Unfortunately, the tort system as currently structured is largely irrelevant to reducing medical error.

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In Reply: The letters from Drs Kopen, Rude, and Foucar implicitly assume that the tort reforms urged by medical societies and malpractice insurers will resolve physicians' problems with the liability system. We doubt this. Caps on noneconomic damages could lower liability insurance rates (by reducing the value of settlements and judgments), but they would do nothing to diminish the sense of unfairness that many physicians associate with the medical malpractice system. This arises from what many see as that system's propensity to attach moral blame when clinical outcomes disappoint, even when physicians do their best.

Diagnostic and therapeutic uncertainty magnify this sense of unfairness. More often than not, science does not decisively answer the question of which diagnostic or therapeutic approach to take. And in the absence of decisive science, different physicians handle similar clinical scenarios in different ways, resulting in wide variations in medical practice. This leaves physicians vulnerable to arbitrary legal outcomes. When a physician opts for treatment A, and the outcome is disappointing, it is often possible to claim (with support from another physician's testimony) that treatment B would have yielded a better result. The medical malpractice system permits juries to affix liability on this basis, after the fact, without scientific proof that treatment B is in fact better. The tort reforms most often urged do nothing to address these problems.

We nonetheless agree with the writers that physicians' bad feelings toward lawyers arise from painful experiences with malpractice plaintiffs' attorneys and cannot be generalized to all lawyers. But we worry that the antagonism has outgrown its roots and has become pervasive. Indeed, Kopen suggests that the 2 professions have profoundly incompatible ethical systems. If these 2 professions' ethical systems are irreconcilable, it is difficult to imagine how the animosity could be limited just to malpractice lawyers.

Despite Foucar's suggestion that trial lawyers and physicians have fundamentally incompatible views, we are considerably more optimistic about the potential benefits from collaboration between physicians and the malpractice bar to address the challenges posed by medical error. To make a difference, this collaboration will need to address the "Russian roulette" features of the malpractice system, as

well as the prerequisites for error reduction, including the building of a stronger science base for clinical decision making.

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RESEARCH LETTER

Constraints on Publication Rights in Industry-Initiated Clinical Trials

To the Editor: Constraints on the publication rights of clinical investigators in industry-initiated trials have been described,^{1,2} but have been investigated in surveys that relied mainly on individuals' recall and attitudes and may have underestimated the extent of its occurrence. We examined directly the presence of constraints in trial protocols and subsequent publications.

Methods. For all 44 industry-initiated randomized trials that were approved in 1994-1995 by the Scientific-Ethical Committees for Copenhagen and Frederiksberg in Denmark and that resulted in publication, we compared the full trial protocols with all text in the subsequent publications (median publication year, 1999), including footnotes and acknowledgments.³ To look for changes over time as a response to new guidelines and ethical requirements, we also assessed the first 44 industry-initiated trial protocols approved in 2004 by the same committees; insufficient time had passed to assess subsequent publications.

For the 2004 protocols, committee requirements removed information that identified particular sponsors, so we limited our examination to whether the investigators had full access to all of the study data and the investigators' publication rights. Two observers independently extracted data. Different observers reviewed the protocol and corresponding article; there was no other blinding. Disagreements were resolved by discussion. Examples of constraints were extracted from the 2004 protocols; they are available from the authors on request.

Results. Of the 44 trials from 1994-1995, 43 (98%) had multinational pharmaceutical firms as sponsors, and 33 (75%) were multicenter and multinational. According to the protocols, the sponsor had access to accumulating data during 16 trials, eg, through interim analyses and participation in data and safety monitoring committees. Such access was disclosed in only 1 corresponding trial article. An additional 16 protocols noted that the sponsor had the right to stop the trial

Table. Constraints on Publication Rights of Nonindustry Clinical Investigators in Industry-Initiated Trial Protocols From 1994-1995 and 2004 and References to Separate Publication Agreements in 2004*

Constraints	1994-1995 Trials, No. (%) (N = 44)	2004 Trials, No. (%) (N = 44)	
		Constraint in Protocol	Separate Publication Agreement
Sponsor owns data and/or needs to approve manuscript			
Sponsor owns data and only sponsor has the right to publish		1 (2)	1 (2)
Sponsor owns data and can publish without informing the investigators	2 (5)	1 (2)	
Sponsor can publish; draft sent to investigators for review		1 (2)	
Sponsor owns data and needs to approve manuscript	5 (11)		
Sponsor owns data and needs to review manuscript	1 (2)	9 (20)	3 (7)
Sponsor owns data	1 (2)	2 (5)	1 (2)
Sponsor needs to approve manuscript	13 (30)	13 (30)	2 (5)
Subtotal	22 (50)	27 (61)	7 (16)
Other constraints			
Sponsor needs to review manuscript	12 (27)	8 (18)	2 (5)
Sponsor's comments should be taken into consideration	1 (2)		
Sponsor's rights will be described in a contract		1 (2)	1 (2)
Investigator can publish but contract will be made		2 (5)	2 (5)
Free publication right but analysis performed by sponsor		1 (2)	
Manuscript prepared in collaboration with sponsor	2 (5)		
If disagreement occurs, both views will be represented	2 (5)	1 (2)	
If disagreement occurs, both parties can publish freely after 3 mo, but sponsor's legitimate interests should be respected	1 (2)		
If disagreement occurs, both parties can publish freely after 3 mo		1 (2)	
Subtotal	18 (41)	14 (32)	5 (11)
Uncertain			
No information on approval or review or on freedom to publish	3 (7)	1 (2)	1 (2)
Publication committee (unclear membership) reviews manuscript	1 (2)	1 (2)	
Subtotal	4 (9)	2 (5)	1 (2)
No constraints			
Free publication right regardless of trial results		1 (2)	

*Percentages in subtotals may differ from sum of individual rows due to rounding. None of the 1994-1995 protocols included reference to a separate publication agreement.