

# Consensus Elusive on Financial Disclosure Issues

BY MICHELE G. SULLIVAN  
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Officials in charge of disclosing financial interests in research agree that disclosure is important, but are confused about how to do so effectively and appropriately, Kevin P. Weinfurt, Ph.D., and his colleagues reported.

Their survey of 42 such officials revealed widely varying opinions on when disclosure should be made, the financial limits that should trigger it, and how much information to share with prospective research subjects, said Dr. Weinfurt of the department of psychiatry at Duke University, Durham, N.C., and his coinvestigators.

"Part of their struggle relates to a lack of clarity regarding the ultimate goals of disclosure," the researchers wrote. "There is also a lack of systematic data regarding how potential research participants can and will use such information in their decision-making" (J. Law Med. Ethics 2006;34:581-91).

The study was based on detailed personal interviews with eight investigators, 23 review board chairs, and 14 conflict of interest committee chairs. The survey was designed to elicit respondents' understandings of how disclosure is done at their institutions and their thoughts on the importance of disclosure, including its risks and benefits to the institution and research subjects.

More than half of those interviewed agreed that disclosure should occur under all circumstances; the rest said disclosure would depend on the degree of the financial relationship. The most commonly expressed reason for disclosing a financial relationship was to facilitate better-informed decision making for potential subjects. Other reasons included trust and transparency issues, reducing liability risk, and managing public perception of the institution.

About 80% of respondents said the disclosure should include the name of the funding source. But some said the name of the company or organization wasn't as important as a description—whether it was a nonprofit organization, pharmaceutical company, or government body, for instance.

They also differed on whether the amount of financial interest should be disclosed. Conflict of interest committee chairs were most likely to want to share this information (93%), while investigators were least likely (63%). Those who expressed concern about disclosing the amount felt that level of detail could become cumbersome or confusing in the informed consent statement, and that research subjects might overestimate the impact that particular amounts might actually have on research outcomes. There

was no consensus on what amount should trigger disclosure—the lower limit ranged from \$1 to \$50,000.

There was general agreement that the nature of the relationship should be disclosed, but no agreement about whether the disclosure should explain the possible impact of those relationships. Again, concern about overcomplicating the consent statement seemed to be at the root of these issues. Some respondents said the disclosure should include an explanation of how an unscrupulous investigator might alter the research results. Most respondents dismissed the idea that disclosure could lower enrollment. There was little sympathy among the group for researchers who complained that full disclosure was an invasion of their financial privacy.

There was also concern about how to best highlight disclosure information without overemphasizing its importance or potential risk to a study's integrity. Some respondents said their consent form highlights the information in bold type, while others place it strategically in the document—at the very beginning, for example. Many also emphasized that the informed consent process should include a discussion of conflict of interest, not just a read-through of the document. ■

**About 80% of respondents said disclosure should include the name of the funding source, but some said a description of the source was more important.**

## Survey Finds Pediatricians in U.S. Satisfied With Well-Child System

BY MARY ELLEN SCHNEIDER  
New York Bureau

Most pediatricians give the U.S. health care system good marks when it comes to providing well-child care, but many also favor changes such as providing some care by phone or e-mail, according to a national survey.

Dr. Tumaini Coker and colleagues at the University of Chicago surveyed 502 pediatricians from around the country about their views of the current well-child system and what would be an ideal way of providing that care. Pediatricians were told to assume that their income would not be affected by the changes they were asked to evaluate for the survey.

The findings show that there is a high degree of satisfaction with the current system for providing well-child visits (Pediatrics 2006;118:1852-7). Nearly all respondents (97%) said the system was excellent or good for providing well-child visits for healthy children, 93% rated it high for chronic illness management, and 88% said it was excellent or good for providing anticipatory guidance. However, pediatricians reported that the system was less well equipped to provide psychosocial screening with only 55% rating it as excellent or good in that area.

While most of the survey respondents reported that currently they perform most components of well-child care (physician exam, anticipatory guidance, developmental

screening, and psychosocial screening) themselves, in an ideal setting 55%-60% said that some of those functions could be performed by non-physician providers.

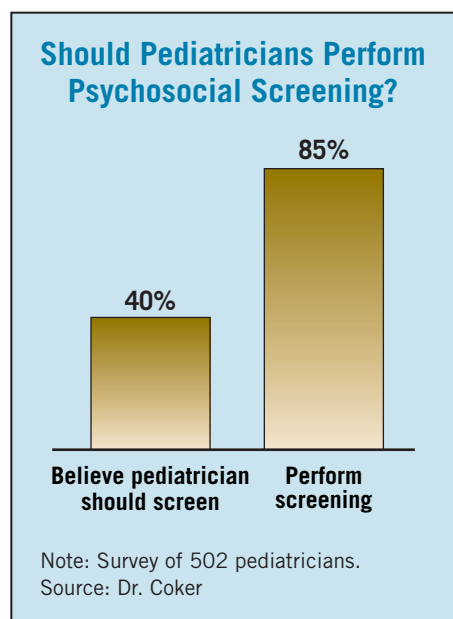
For example, when asked who should be the main provider of services in an ideal system, 40% said that psychosocial screening should be done by the pediatrician; 40% said it should be done by a nurse practitioner or physician assistant; and 20% said it should be done by a registered nurse or medical assistant.

More pediatricians (76%) thought it was important for the pediatrician to continue to perform the physical exam in an ideal system, while the remainder said it should be done by a nurse practitioner or physician assistant.

Physicians also were supportive of replacing some in-person office visits with phone or e-mail consultations. For example, 64% of pediatricians surveyed that said much or some anticipatory guidance could be provided by phone or e-mail,

and 29% said that "a few" services could be provided by phone or e-mail. In addition, 57% of pediatricians said that many or some visits for minor acute care could be handled by phone or e-mail, and 33% said that a few such visits could be replaced with calls or e-mail.

The surveys were mailed to a random national sample of 1,000 pediatricians under age 70. There was a 60% response rate, with 502 pediatricians returning the survey. The study was supported by the Robert Wood Johnson Clinical Scholars Program. ■



## AAP Releases Phone Care Toolkit, Policy Statement

BY MELINDA TANZOLA  
Contributing Writer

A practical toolkit and policy statement to help pediatricians build a system to bill for telephone care in their practices are now available from the American Academy of Pediatrics.

Dr. Peter Dehnel discussed practical considerations for implementing a telephone care billing system at the annual meeting of the American Academy of Pediatrics.

"The most important reason [to bill for telephone care] is so that we in primary care, as well as all pediatricians, can provide a higher quality of service for our families in a way that's more timely and effective and efficient to them," said Dr. Dehnel, medical director of the Children's Physician Network's Nurse Triage Program in Minneapolis.

The toolkit, available from the Member Center at the academy's Web site, [www.aap.org](http://www.aap.org), under the New Books and Publications section, contains many resources to walk pediatricians through the process of developing a telephone care system. Documents include a clinic policy statement, a documentation template for recording an assessment of the patient's condition and evidence of medical decision making, a billing document, information on preparing parents and families for the change, a list of conditions for which telephone care should be included, and data- and information-tracking resources to

help a practice manager measure the outcomes of the new endeavor.

Pediatricians also are encouraged to review the policy statement on telephone care published in the October issue of Pediatrics (Pediatrics 2006;118:1768-73). The statement, written by members of the AAP's Section on Telephone Care and the Committee on Child Health Financing, discusses the function of telephone care and the current state of billing for phone care and gives practical recommendations for instituting a billing system.

Dr. Dehnel recommended that practices adopt a consensus or majority vote and not allow one naysayer to sway the office against adopting a telephone care billing system.

After the decision is made to initiate billing, Dr. Dehnel suggests that one physician and one administrator in each practice should act as the local telephone care experts, which can help the practices adopt a smooth-running telephone care system.

Finally, it is important for pediatricians to adequately prepare families for the change in billing by notifying them of the new policy, what calls will be included, and how the insurance process will work. "It is extremely important to use more than one means to notify your families," Dr. Dehnel said. He suggested using office posters, an article in the office newsletter, and certainly mailings as ways to inform families about the change. ■