done promptly, and the reporting mechanism, such as an honor board, should be different than that for peer assessment. Because medical education curricula, opportunities for student contact, trust in the administration, and advising systems are quite variable, it will be important for each school to involve students in the design and implementation of peer assessment systems. Ideally, structured peer assessment could identify and encourage correction of concerning behaviors in a student before a serious lapse occurs, particularly if safe, proactive mentoring is available. It is possible that in an environment in which this sort of peer feedback is routine, reporting of serious lapses, as to an honor council, may be facilitated.—**Anne C. Nofziger, MD, Stephen J. Lurie, MD, PhD, Ronald M. Epstein, MD**, *Department of Family Medicine, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA.*

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Authors' Response

To the Editor:—Thank you for this opportunity to comment on the letter to the editor by Nofziger et al.¹ about our article. We conducted 16 focus groups with medical students to identify factors that according to students themselves would encourage or discourage their participation in assessment of unprofessional and professional behavior of peers. Contrary to Nofziger and colleagues' contention, we did not present peer assessment to students as a "mechanism for reporting classmates' behavior." Rather, we carefully framed the focus group questions more generally with the operative words "sharing information about classmates' behavior."² The questions did not directly ask students to think about peer assessment as "reporting classmates' behavior."² That said, students did discuss the prospect of reporting peers' behavior to various individuals and groups in the school.

Nofziger et al. advocate distinguishing peer assessment for feedback (a formative use) from reporting peers' behaviors to others (a "punitive" use). As stated in our article, students in our focus groups clearly preferred informal peer-to-peer feedback for formative purposes—except when the peer engages in frequent or egregious unprofessional behavior. But they themselves did not suggest the distinction that Nofziger et al. recommend. Moreover, they recognized that peer assessment could have positive consequences for a classmate with exemplary professional behavior (e.g., election to an honor society) and for a classmate with unprofessional

behavior (e.g., behavioral change achieved through guided instruction).

The critical point is that students say they want and need a safe environment before they will participate in peer assessment, as described in our article. We agree with Nofziger et al. that separating peer assessment for formative and summative uses could contribute to the safety of the environment. In this regard, as students in the focus groups suggest and we included in the article, who receives the peer assessment is important. Students mentioned a range of possibilities including an Honor Council. Whether Honor Councils function effectively, as Nofziger et al. believe, may require systematic study; we do not know of any research documenting the role of Honor Councils in changing unprofessional behavior of students.

The main thrust of our work is not specifically to promote either the reward or punishment of students. It is to recommend that in order for peer assessment to reach its full potential as an assessment technique (formative, summative, or both), schools must understand their students' perspectives on the characteristics of an assessment system that will promote their participation.—**Louise Arnold, PhD, Carolyn K. Shue, PhD, David T. Stern, MD, PhD**, *Office of Medical Education & Research, University of Missouri—Kansas City, Kansas City, MO, USA; and University of Michigan Medical School/VA Ann Arbor Health Care System, Ann Arbor, MI, USA.*

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Comments on Shrank et al., Focus Group Findings About the Influence of Culture on Communication Preferences in End-of-Life Care

To the Editors:—Shrank et al.¹ have published interesting data about culture-based preferences for end-of-life care discussions. The data suggest that Euroamericans (EAs) and African Americans (AAs) alike value patient autonomy, advance directives, and input from various health professionals. Further, EAs want only "closest" family members in on decision making, seek technical guidance, base decisions on quality of life, and trust health professionals. In contrast, AAs want family and friends in on decision making, seek spiritual guidance, base decisions on possible miracles and protecting life, and distrust health professionals.

Yet one comment by the authors surprises us: "... this is the first study to explore patient preferences (about) end-of-life discussions, with a focus on ... cultural differences ..." Actually, we have already published such data, even in this journal.^{2–4}

Many of our data are corroborated by those of Shrank and colleagues. Like them, we found that EAs and AAs believe in patient choice, advance directives, and family participation in decisions. Both groups believe that advance directives improve the chances that patient choices will be honored, and want a particular family member as a proxy. Euroamericans tend to trust that health professionals honor patients' wishes and to refuse life support based on quality-of-life considerations (including functional outcome and hospitalization requirements for aggressive care). In contrast, AAs tend not to trust that health professionals honor patients' wishes and to request life support for as long as possible.²

But our data differ from those of Shrank and colleagues in important ways. Unlike them, we found that EAs prefer to talk about death beforehand; AAs do not.⁴ Euroamericans also tend to believe that they can control treatment and, thus, want to express their wishes to physicians. In contrast, AAs tend to believe that the health care system—not patients—controls treatment and, thus, hesitate to express their wishes to physicians.² We also found important gender differences. Specifically, more women than men in both ethnic groups trust the health care system to empower patients and respect their wishes.³

Taken together, all four articles¹⁻⁴ reveal general (but not necessarily uniform) preferences within ethnic groups and genders. Knowing these preferences gives health professionals a place to start end-of-life care discussions. Yet the greatest challenge is recognizing variation within groups and avoiding harmful stereotyping. We welcome future contributions by Shrank and colleagues and others to this important field.—**Henry S. Perkins, MD, FACP, Emi Ponce De Souza, BS, Josie D. Cortez, MA, Helen P. Hazuda, PhD, The University of Texas Health Science Center, San Antonio, TX, USA.**

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RESEARCH LETTER: Do Physicians Discuss Political Issues with Their Patients?

To the Editor: Politicians have an important influence on the structure and function of our health care system. As a result, it seems likely that physicians and their patients might discuss political issues of consequence to health care. Yet, little is known about physicians' attitudes and activities in this regard or about their level of personal political participation.¹⁻⁴ We conducted a survey to examine the political attitudes and activities of physicians and to identify characteristics associated

Table 1. Political Activities and Attitudes of UPHS Clinician Cohort (N = 36)

Variables	N (%)
Currently registered to vote	36 (100)
Personal political activities in the last decade:	
Voted in a national election	35 (97)
Contributed money to a political campaign	23 (64)
Attended a political campaign event	13 (36)
Volunteered time to a political campaign	7 (19)
Interactions with clinic patients in the last decade:	
Had a discussion about voting	31 (86)
Initiated a discussion about voting	15 (42)
Discussed a politically oriented health care issue	30 (83)
Initiated a discussion about a politically oriented health care issue	17 (47)
Agree these politically oriented activities are appropriate in clinic:	
Remind patients to vote through clinic brochures	30 (83)
Remind patients to vote through direct discussion	21 (58)
Inform patients about politically oriented health care issues through clinic brochures	18 (50)
Discuss politically oriented health care issues with patients	15 (42)

UPHS, University of Pennsylvania Health System.

with physician willingness to address political issues with clinic patients. We developed a 23-item, 1-page questionnaire and pilot tested it with 8 physicians. The instrument measured personal political activities, political activities in the clinic, and attitudes about addressing political issues with clinic patients. Excluding demographics, response options were dichotomous (yes/no) or 5-point Likert scales. The University of Pennsylvania Institutional Review Board approved the study, which was conducted after Pennsylvania's voter registration deadline but before Election Day (October 5 to November 1, 2004). All primary care physicians (PCPs) in the Division of General Internal Medicine practicing in the University of Pennsylvania Health System were asked to complete the questionnaire. Six practices in urban and suburban Philadelphia were surveyed. Hospitalists and clinician-researchers were excluded. Participation was optional and consent implied. Questionnaires were self-administered and anonymous. For analyses, Likert responses were dichotomized (agreement/disagreement) and "unsure" responses were excluded. Bivariable associations were examined with χ^2 or Fisher's exact tests as appropriate using STATA 8.0 (Stata Corp., College Station, Tex). Of the 37 eligible PCPs, 36 (97%) participated. Study PCPs practiced clinical medicine for medians of 9 years (25% to 75% interquartile range (IQR) 7 to 15) and 32 hours per week (IQR 20 to 40), and 19 (53%) were male. All PCPs had indigent patients but 6 (17%) primarily served patients with annual household incomes less than \$25,000. Table 1 summarizes our survey findings. Overall, 34 PCPs (94%) discussed voting or a politically oriented health care issue with a patient and 20 (56%) initiated such discussions. Twenty-two (63%) were willing to offer voter registration in their clinics, while 30 (83%) were willing to offer information on voter registration. Thirty-one (86%) agreed that political communication with patients, either through brochures or direct discussion, was appropriate. Male PCPs were more likely to contribute money to political campaigns (15 of 19 vs 8 of 17, $P = .05$) and to initiate discussions with patients about politically oriented health care issues (12 of 19 vs 5 of 17, $P = .04$). Physicians who contributed money or volunteered time to political cam-