tients' characteristics at eligibility for interferon beta treatment (ie, the study baseline), showing that this results in substantial bias (for either the historical or contemporary control groups), or attempting to adjust for this possibility, is challenging, with few well-validated methods available. Ideally, every time a patient's treatment status changes, other important changes in his or her profile would be accounted for. Gaining this level of dynamic detail may not be possible. We are currently investigating several possible approaches, including marginal structural models.[1] However, accurately estimating the various weights required by such models is challenging, and careful validation in MS is needed.

A major strength of our study was the inclusion of both a historical and contemporary control group.[2] As Goodin and colleagues note, around 20% of the patients in the historical untreated cohort were excluded due to subsequent exposure to interferon beta. We did, however, perform a sensitivity analysis including these patients (eFigure 7 in article). This did not change our conclusions. Yet, we agree that a cohort that never had access to treatment (if they could be found) might serve as a better control cohort.

We cited a different study from the 16-Year Long-Term Follow-up Study Investigators.[3] Similar to our results, that study did not demonstrate an association between interferon beta exposure and disease progression (EDSS score of 6 or secondary-progressive MS), albeit in a smaller cohort of patients previously enrolled in a clinical trial. Using a different method, the beneficial effects of interferon beta on the same outcomes were later reported.[4] A 21-year follow-up study of the same cohort, focusing on mortality,[5] was published after our article was submitted for publication.

Our study has an important role in providing evidence of effects that cannot be adequately studied in randomized controlled trials. That said, there still remains a need for more real-world pharmacoepidemiological studies in MS. Pragmatic clinical trials or effectiveness trials[6] would also be desirable, especially in such a heterogeneous and slowly evolving disease with few good surrogate markers of disease progression. Exploration of heterogeneity of treatment effect across subgroups and a meta-analysis of similar observational data also would be useful.

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Requirement to Purchase Health Insurance

To the Editor: Dr Rulli and colleagues[1] claimed that a physician's duty to provide acute and emergency care, ie, to rescue, is "not grounded solely in individuals' right to be rescued." Without this claim, their argument that the duty to rescue grounds a duty to buy insurance is less interesting because if individuals can waive their right to rescue, citizens can escape the duty to buy insurance.

If the duty is not grounded in individuals' right to be rescued, it is either owed to someone else or it is owed to no one. If it is to be owed to someone else, it is unclear to whom. The answer may be society, but the authors explicitly denied that they are taking this option. Alternatively, if it is owed to no one, the argument will be controversial because many moral theorists believe that moral obligations must be owed to someone or something (eg, an animal).[2,3] For instance, lawyers' duties are owed to clients; likewise, physicians' duties are owed to patients or the public. If the authors intended this view, they should offer some support for it.

Perhaps their claim that the duty is grounded in "a requirement of benevolence and compassion at the core of medicine" is meant to support this view. Perhaps they agree with Pellegrino[4] that medical duties are grounded in "the nature of the clinical encounter between physician and patient," rather than in general moral duties to each other. Unfortunately, this view is controversial because it may deprive medical duties of authoritative force. It is clear that one ought to fulfill one's medical obligations if they are grounded in moral obligations, but if not, it becomes hard to account for their authority.[5] Compare, for example, the force of rules of etiquette: I might violate etiquette by using the wrong spoon, but I have not done anything that I must avoid.

Regardless of these worries, the authors have reminded readers that individuals' duties to each other depend on the benefits, risks, and burdens involved, a point which some arguments against the universal mandate may neglect. Liberty does not always override the duty to rescue; if eating broccoli was necessary to rescue a life, it would be a duty—so too for other obligations. Fortunately for those who dislike broccoli, they are at liberty not to eat it because eating broccoli does not save lives; buying health insurance does.

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In Reply: We claimed that the duty to rescue is not grounded in individuals' rights to be rescued. It follows that individuals cannot avoid the obligation to buy health insurance simply by waiving their putative right to be rescued. Mr Smith writes that because we failed to specify to whom this duty is owed, we seem committed to the claim that the duty to rescue is not owed to anyone. This is at odds with the views of some philosophers, including Darwall, who hold that duties must be owed to someone.[1]

Our claim is that the duty to rescue is not rights-based. This claim is consistent with the possibility that the duty to rescue is owed to someone. For Darwall,[1] moral duties are owed to the moral community and are tied to what the moral community has the authority to demand. This view provides one way in which the duty to rescue might be owed to someone without being rights-based.

While we did not consider them in our Viewpoint, there are good reasons to reject a rights-based duty to rescue. Consider a case of several children drowning in a pond.[2] You can easily save one child, but do not have time to save any more. Clearly you have a duty to rescue one child. If the duty to rescue is grounded in rights, then you have the duty because at least one of the children has the right to be rescued. But if one child has the right, they all do for they are all in the same situation. Hence, no matter which child you save, you will violate the rights of all the other children. It seems implausible that in doing your best, you violate many individuals' rights to be rescued.

One might respond that the duty to rescue is rights-based when all who need rescue can be rescued, but is not rights-based when the number who need rescue exceeds the number who can be rescued. This seems an implausible view. A more plausible view endorses the same grounds for rescue in both cases. Darwall's account does this.[1] We offered another: the duty to rescue is grounded in the requirement of benevolence.

Additionally, rights-based duties to rescue are less capable of explaining the kind of case we were interested in—in which the need for rescue might involve the individual's negligence. Whether one has a duty to rescue does not depend on whether the individual is the kind of being that can be a holder of rights, who has not previously waived the relevant right, and has not done anything to lose his or her claim, such as acting with negligence or recklessness. It depends on whether the individual is in urgent need and a physician can rescue him or her. Physicians should rescue people because it is what benevolence and compassion—or, perhaps, the moral community—demand.

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RESEARCH LETTER

A Prognostic Assay to Identify Patients at High Risk of Mortality Despite Small, Node-Negative Lung Tumors

To the Editor: Low-dose computed tomography screening[1] may increase diagnoses of T1a node-negative non–small-cell lung cancers (NSCLC). One-quarter of these patients die within 5 years.[2] Maximizing the benefit of screening requires a reliable method to identify patients with high mortality risk. A molecular prognostic assay has been clinically validated for nonsquamous NSCLC, but performance of the assay was not studied in small node-negative tumors.[3]

Methods. A total of 1439 patients who had undergone resection of nonsquamous NSCLC in either the Kaiser Permanente Northern California system between 1998 and 2005 or at 1 of 3 institutions from the China Clinical Trials Consortium between 2000 and 2008 were enrolled in 2 original validation studies using consecutive sampling (follow-up end date: May 31, 2011).[3] All patients with node-negative tumors of less than 2 cm from the Kaiser system (n=155 patients) and the China Consortium (n=114 patients) were included in this study.

The prognostic test measures the expression of 14 genes using quantitative polymerase chain reaction on RNA extracted from formalin-fixed paraffin-embedded specimens, and assigns patients to low-, intermediate-, and high-risk