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**Conflict of Interest Disclosures:** The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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**In Reply** We agree with Mr Dove and Dr Prainsack that an individual's decision to donate samples and medical information to a biobank is influenced by many factors, including those they describe. That makes it no less true, however, that a decision to donate may also be affected by a large range of moral concerns over future research possibilities, represented only in part by the scenarios presented in our survey.

As Dove and Prainstock suggest, that range of possibilities is essentially unlimited and unpredictable, all the more so with the increase of data sharing on an international scale. Individuals who donate to future biobank research during their participation in a clinical trial evaluating new treatments for their medical condition, for example, cannot expect that such research will be confined to that subject. That is why it is common practice in the United States to get a separate consent for the biobank donation that usually gives explicit permission to use it and its associated data in any future research for which it is suitable. Thus, whatever their starting points, most donations of specimens and associated medical information will produce data likely to end up in a research biobank.

The willingness to give an open-ended consent is what we were evaluating in our survey. Although some draw a distinction between broad and blanket consent, in either case donors give consent to unknown future uses. The distinction, then, is not pertinent to our finding that willingness to give that consent is affected by the mere possibility of research uses that might be of moral concern to some people.

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## Antibiotics for Children With Acute Otitis Media

**To the Editor** In the From the JAMA Network commentary<sup>1</sup> on a trial of antibiotics for children with acute otitis media in Finland,<sup>2</sup> Dr Pichichero suggested that the pendulum should move from the current recommendations of the American Academy of Pediatrics for watchful waiting before prescribing antibiotics back toward their greater use of the past. We have 3 reasons for disagreeing.

First, the innovation of the Finnish trial was to increase the diagnostic rigor of acute otitis media (by use of pneumatic otoscopy, as well as special validation against tympanocentesis and tympanometry).<sup>2</sup> Increasing the rigor of diagnosis may well provide a purer sample, less diluted by cases that are not acute otitis media. However, achieving this rigor may not be achievable in primary care, and therefore these results may not be generalizable. Yet family physicians may be tempted to apply the results anyway.

Second, the Finnish trial used a surrogate principal outcome of middle ear effusion. Most children (and their parents) are not concerned with whether there may be residual fluid in the middle ear. They are only concerned if there is systemic illness, pain, or deafness (the principal patient outcomes that affect health in a self-remitting illness). The publication of systematic reviews<sup>3</sup> reporting on these more relevant outcomes have led to a move away from routine use of antibiotics for acute otitis media.

Third, any recommendation that may increase use of antibiotics in primary care will contribute to antibiotic resistance, which is now a serious threat to global public health.

Instead, we advocate moving away from the dichotomous position suggested by the "yes or no" of the commentary's title<sup>1</sup> toward shared decision making.<sup>4</sup> Benefits should be balanced against harms, which include common adverse events and antibiotic resistance, not just for the community but also the individual.<sup>5</sup>

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2. Tapiainen T, Kujala T, Renko M, et al. Effect of antimicrobial treatment of acute otitis media on the daily disappearance of middle ear effusion: a placebo-controlled trial. *JAMA Pediatr*. 2014;168(7):635-641.
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**In Reply** I am in full agreement with Dr Del Mar and colleagues that accurate diagnosis is an essential component to endorsing the use of antibiotics for acute otitis media. If a child does not have acute otitis media in the first place, then no antibiotics are necessary. In the meta-analyses and reviews showing marginal benefits from antibiotics, it is likely that as many as half of the included patients did not have acute otitis media,<sup>1,2</sup> thereby diluting the true benefit of antibiotics that occurred in the children who were correctly diagnosed.

Moreover, I contend that pediatricians and family physicians can be trained on the criteria for making more accurate diagnoses of acute otitis media.<sup>1,2</sup> Such training can result in a sustained effect.<sup>3</sup> The focus of misuse of antibiotics should be on the many children receiving antibiotics for the common cold and cough illnesses and not on those with true acute otitis media, which is a bacterial infection that can be resolved more quickly with antibiotic treatment.

Furthermore, whereas the study by Tapiainen et al<sup>4</sup> used persistence of middle ear effusion as the primary outcome (which I disagree with Del Mar and colleagues is not important),<sup>2</sup> other recent studies showed broader and clinically important improved outcomes from appropriately selected antibiotics.<sup>5,6</sup>

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