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No Free Lunch

Steven Reidbord, MD

Pharmaceutical promotion is big business. In the US alone, the industry spends billions each year (about \$16 billion in 2000) to market its products. Most of this budget pays for extensive, multifaceted marketing to doctors, much of it delivered in person by salespeople called “pharmaceutical representatives.” A smaller but still sizable portion of funds produce direct-to-consumer “ask your doctor” ads on television and elsewhere. Pundits debate whether such lavish promotion drives up the cost of health care or helps to contain it, whether it enhances or detracts from patient care. Most of this focus has been on the industry side of the equation. Yet medical ethics demands that we physicians assess the other side of the equation: our own participation in these promotional efforts.

Advertising and product promotion are everywhere in our society, exerting their influence in largely non-rational ways. We imagine that we rationally weigh the features and benefits of competing products and make logical choices. Yet advertisers “sell the sizzle, not the steak.” Catchy jingles, the look of a product and its packaging, celebrity endorsements, associations with attractive people or lifestyles — these appeal to our emotions, often bypassing intellect and logic. In everyday life we sense no ethical impropriety in allowing ourselves to be influenced this way. Who knows, or cares, why we prefer one brand of soap over another? If we choose a household product for its captivating name or fancy packaging we may be misguided or superficial, but we are certainly not evil. We face no ethical dilemma in

accepting a free food sample at the supermarket, even if it evokes pleasant associations in us about being fed or induces a subtle wish to reciprocate the generosity. Marketing works at both surface and subterranean levels. As a society we accept that.

Patients do, and should trust, that their doctors are dedicated to their welfare. The idea that a doctor might have a conflict of interest between serving a patient and some other goal seems strange and even abhorrent. However, in the complex world of modern medicine, these conflicts do arise. The marketing of pharmaceuticals presents one example. In this article, Dr. Steven Reidbord, a CPMC psychiatrist who teaches ethics to psychiatry residents, expresses his view on this issue.



“No Free Lunch” continued on page 4

The Ethicist is In

Steering Clear of Organ Tourism

Today's Ethicist is **Katrina A. Bramstedt, PhD**



Mrs. Wilson, a long-time dialysis patient of Dr. Smith, recently returned from a three week trip to Pakistan. While there, she received a kidney transplant from a living donor who was unknown to her. Since returning to the US, she has experience painful urination and lower back pain. She phoned Dr. Smith to schedule a clinic visit and he was surprised to learn she had received a kidney transplant overseas. Also, he was ethically disturbed to learn the patient had purchased the organ.

“Foreigners OK” and “No waiting period” are examples of lures used by overseas hospitals in an attempt to attract US patients to their transplant centers. Indeed, the desperation of some patients has led them to venture to an international location in order to undergo solid organ transplantation. This is because in the US, some patients find themselves waiting several years for a kidney transplant, for example. While waiting, they endure the burdens of dialysis and risk further deterioration of their health. The practice of traveling overseas for the express purpose of

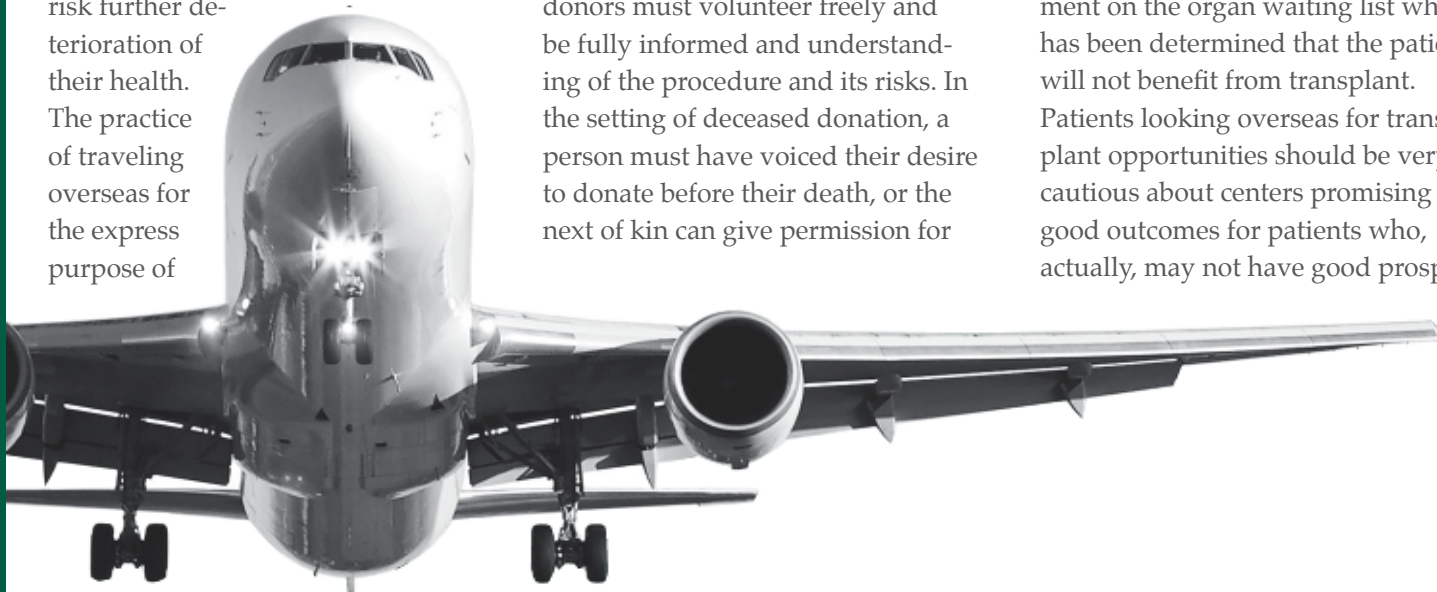
obtaining an organ transplant is commonly known as organ tourism. Patients and their families need to reflect on the risks and ethical issues associated with this practice.

It is widely known that some organs transplanted at overseas hospitals originate from people who were not able to give informed consent to donation. Some examples are forced donation from prisoners (China), forced living donation from spouses (India), living donation from those who are uneducated and unable to understand the risks and consequences (India, Pakistan, Philippines), and living donation from the poor who see such as a way of generating income to meet their daily needs (India). In the US, informed consent is highly valued and a requirement of our transplant process; however, not all countries share this value. In the US, organ donation is a voluntary procedure and the organ is a free gift to the patient. In the setting of live donation, donors must volunteer freely and be fully informed and understanding of the procedure and its risks. In the setting of deceased donation, a person must have voiced their desire to donate before their death, or the next of kin can give permission for

donation if he/she believes the person would have wanted to be a donor.

Similarly, in the US, the safety of living donors is very important and all transplant centers have a donor advocate or donor advocate team to ensure their safety, welfare, and informed consent. It is not clear that countries outside of the US have such safeguards for their live donors. In India, for example, many donors suffer significant medical complications and often regret having participated as a donor. Further, the income they generated by selling their organ in no way removes them from their state of poverty.

Another fact to consider is that overseas transplant programs may have looser criteria for accepting patients onto their transplant waiting lists. This might seem like a good idea; however, looser criteria can also mean giving patients and families false hope for transplant success. In the US, a patient is declined for placement on the organ waiting list when it has been determined that the patient will not benefit from transplant. Patients looking overseas for transplant opportunities should be very cautious about centers promising good outcomes for patients who, actually, may not have good prospects



of benefiting from transplant. These unrealistic expectations can also be financially costly to patients and their families.

US transplant teams sometimes encounter patients who have participated in organ tourism, then seek post-transplant care in the US. This can cause great ethical discomfort for these doctors and nurses. Sometimes they return to the US with inappropriate immunosuppressant drugs (medication intended to prevent organ rejection) from the foreign hospital. Sometimes these patients return with complications such as serious infections (including HIV and hepatitis) and they lack copies of their medical records (or they are written in a foreign language). Legally and ethically, doctors have the right to abstain from caring for organ tourism patients unless the situation is an emergency.

At CPMC we strongly discourage patients from participating in organ tourism. If you are a patient who has been waiting a long period of time for organ transplantation (or family of someone waiting) we encourage you to discuss your transplant options with the medical team. Potential options include placement on the transplant waiting list of multiple hospitals concurrently, living donor transplantation (liver, kidney, lung, pancreas, intestine), paired kidney exchange (finding a living donor using a database of potential live donors), and destination therapy using a left ventricular assist device (for patients with end stage heart failure). Although we are frustrated by the US donor organ shortage, we are ethically troubled by the practice of organ tourism and do not support any efforts that might encourage these practices.



Happenings

Bramstedt Interviews and Lectures:

Dr. Bramstedt led a training session for a group of visiting Emory University personnel. She also had the pleasure of being interviewed by the San Diego Westview High School newspaper, as they discussed the ethics of warning labels on energy drinks as it impacts the caffeine use of teenagers.

New Mexico lecture:

Dr. Jonsen was invited to Albuquerque Presbyterian Hospital in New Mexico where he was joined by our visiting scholar, Dr. Larry Schneiderman. These two gentlemen addressed ethical decision making in clinical medicine.

Bay Area lectures:

Dr. Jonsen gave two lectures to the UCSF School of Medicine; *"How technology challenges the ethics of medicine"*

was presented in September. His October lecture was titled *"A new ethic for health professionals."* Dr. Andereck gave his annual ethics training to the Geriatrics Nursing team.

Andereck lecture:

Dr. Andereck gave an ethics lecture at Northridge Hospital Medical Center in southern California.

Grand Rounds:

Our Program has reached out to all medical departments within the medical center in hopes of leading grand rounds on ethics during the new academic year. The first of these grand rounds were presented to the Transplant service, then to Anesthesiology, as a thorough explanation of what an ethics consult is and how the consultation service works.

Fundraising

As year end approaches, many of you consider your charitable giving for 2008. We know that charitable gifts are restrained in economic times such as these, but we hope that the desire to aid worthwhile projects, such as our Program in Medicine and Human Values, remains strong. The Program continues to depend on the kindness of our donors to pursue our work of improving patient care by an effective program of ethics consultation and education. Your continued support has been greatly appreciated.



Our Ethics Intervention Project, now being conducted in CPMC's intensive care unit, aims to demonstrate that prompt ethics consultation can improve many of the distressing circumstances of care in an intensive care unit. This Project has recently received a \$100,000 matching grant moving us halfway toward the

Continued on page 5

Likewise, it is not ethically problematic for patients to respond to television ads by "asking their doctors" about prescription medicines, even though these ads employ the same non-rational enticements used by other industries, such as memorable product names, evocative catch phrases, and scenes of active, happy people. (Some argue it is unethical for the companies to advertise this way, but that is not our focus.) A patient may inquire about a particular medicine for countless reasons, ranging from careful research, e.g., on the Internet, to an offhand comment by a friend. There is no requirement or expectation that a patient's interest be rationally based. From the patient's perspective, there is nothing wrong in hearing about a medicine, even from an ad, and asking one's doctor about it.

The physician, however, is in a very different position. There is an expectation that a doctor's interest in a particular treatment be rationally based. Moreover, medical ethics requires it.

The doctor-patient relationship is fiduciary. It is founded on the patient's trust that the doctor always practices medicine in the patient's best interest. Like other fiduciary relationships (e.g., bank-customer, corporation-shareholder, and attorneys and accountants with their clients), the doctor-patient relationship is vulnerable to conflicts of interest that can undermine trust. In all of these fields, professional ethics dictate that the trustee take reasonable steps to avoid conflicts of interest and divided loyalties.

Physicians in particular must strive to practice medicine in an unbiased, scientific fashion. This is more difficult than it sounds, since influences that are widely accepted and



considered benign in everyday life can represent trust-threatening conflicts of interest here. The non-rational influences of product promotion — the gratifying visits by friendly, attractive salespeople bearing personal gifts and free food — directly threaten the fiduciary doctor-patient relationship. By participating in these encounters, physicians actively invite non-rational bias into treatment decisions, in direct violation of the trust patients place in us. It follows that medical ethics should condemn active involvement in this process by physicians, and that reasonable steps should be taken by ethical physicians to avoid participation in promotional activities.

Many physicians defend current practice by claiming that they are immune to non-rational promotional efforts. The pharmaceutical industry does its best, they say, but smart doctors see through the attempted influence and "ignore" it. This rebuttal is not new.

An historical review (1) in a recent issue of JAMA quotes the same view from apologists 50 years ago. However, then as now, there is no evidence that doctors enjoy any special

resistance to non-rational product promotion. On the contrary, several empirical studies document the effectiveness of such promotion in swaying the prescribing patterns of doctors. It is tortured logic to assume that a sophisticated industry wastes billions every year on harmlessly ineffective promotional efforts — especially when the very same strategies work well in other industries. Wishful thinking and hubris alone cannot stand up to this evidence.

Increased public scrutiny has prompted modest reforms over the past few years. A growing number of medical centers and teaching institutions now restrict promotional activities on campus. The pharmaceutical industry itself has voluntarily dropped or limited some types of product promotion. Congress is working on legislation requiring public reporting of industry largesse to doctors. These actions recognize the seriousness of the problem. But,



beyond all efforts to prevent undue compensation or to make it transparent, the ethics of the physician are the strongest bulwark against improper influence on prescribing practices. Unfortunately, at this time only a small percentage of individual doctors decline sales calls and similar contact with industry. Surveys show that patients express more concern than physicians over this issue.

Being a physician bestows many rewards and gratifications. These

are balanced by the restrictions on our actions that are part of ethical practice. We must act professionally and always in our patients' best interest. We must be competent and skillful, stay current in our field, and use evidence-based approaches when possible. We must strive to avoid making clinical decisions based on non-rational factors. While this ethical restriction may deprive us of branded coffee mugs and pens, free lunches, and opulent sponsored "educational" dinners, it is a small

price to pay for earning our patients' trust.

(1) Podolsky SH, Greene JA, "A Historical Perspective of Pharmaceutical Promotion and Physician Education," *Journal of the American Medical Association* 300(7), 20 August 2008, p 831-833.

Fundraising continued from page 3

remaining \$200,000 needed to complete this ground breaking study.

We continue to provide personal ethics consultations to all who request them. We do not charge for this service, since insurance does not reimburse it. Our annual colloquium of bioethicists contributes to the practical knowledge of ethics in a community hospital. Also, we provide ethics education to all of our staff on a regular basis. Our newsletter, *Ethical Times* which goes to 1000 of our staff and our supporters also advances that education. Your contributions are necessary to support these important activities.



Nonbeneficial Treatment:

Program Staff Develops New State (And National?) Medical Policy

By Steve Heilig

Many if not most requests for ethics consultations are in some way related to end-of-life care decisions. The most difficult cases occur when physicians feel they are being asked to provide treatments which they believe will not benefit the patient, and will only prolong inevitable dying. State laws, and policies of the American Medical Association and California Medical Association allow physicians to refrain from providing such treatments. However, some doctors are fearful of being sued by understandably distraught family members. The result has sometimes been continued treatment that physicians and others feel is inappropriate, even unethical.

With this dilemma in mind, our program staff, including Dr. Andereck and Steve Heilig,

supported by the San Francisco Medical Society, drafted and took a new policy proposal to the annual California Medical Association conference in October. This proposal states that CMA "supports physicians who appropriately invoke and follow accepted ethical, regulatory, and institutional policies regarding decisions to forego futile or non-beneficial treatment." CMA will work with hospitals and others to ensure that physicians are not penalized for doing so. The proposal was adopted by the CMA which will now take this policy to the AMA for national adoption. If this increased support proves reassuring as intended, the result could be better adherence to accepted medical and ethical standards. It should also alleviate considerable distress and misunderstanding during care for patients at the end of life.



Book Review

Martin, Lesley (2002) *“...to die like a dog.”*

New Plymouth, NZ: M-Press (Ltd)

Reviewed by Atiba Rougier

(PMHV summer intern)

The topic of euthanasia is again in the news. Stedman's Medical Dictionary, 27th Edition, defines euthanasia as “1. A quiet death. 2. The intentional putting to death of a person with an incurable or painful disease intended as an act of mercy.” In June 2008 the *Marin Independent Journal* reported that a registered nurse from Novato was charged with endangering an elderly or dependent adult (her mother) by injecting her with a potentially fatal dose of morphine. According to the charges, the daughter claims that her mother was in a lot of pain, wanted to die, and took the morphine herself in the middle of the night. Her mother, who survived the episode, argues that she did not want to die and did not administer the morphine herself. In July 2008, the *New York Times* reported the unabashed sale of pentobarbital from veterinary supply stores to the general public, many of whom are US customers, for the purpose of human euthanasia (“In Tijuana, a Market for Death in a Bottle”). Although euthanasia is illegal in the US and most countries, it is controversial and sometimes covertly practiced.

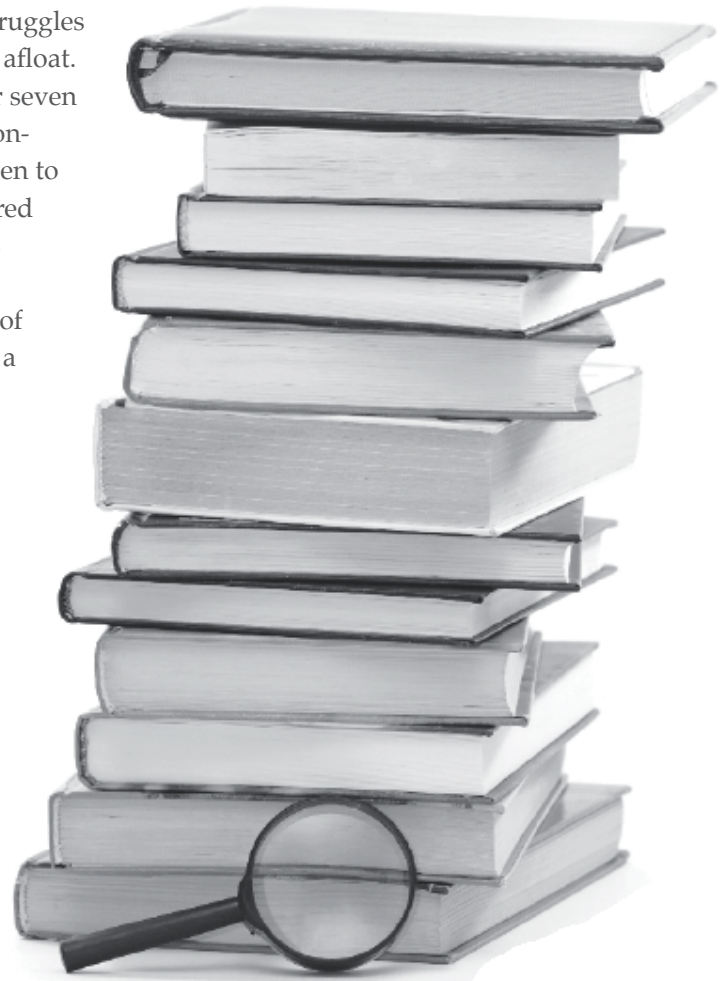
In the Western world, dying with dignity is often viewed as dying peacefully, quickly, and without pain. While such a death is a goal of many patients, they also fear that their death will not be dignified, but rather filled with pain, suffering, and other burdens for themselves and their families. In Lesley Martin's book, *“...to die like a dog,”* the reader is given

a first-hand account of a daughter's dilemma to devote herself to her mother's dying wish to not “die like a dog.” This semi-autobiographic story is no contemporary best-seller like “Tuesdays with Morrie” or an anatomical and physiological description of what happens when we die (“How We Die” by Sherwin B. Nuland), but a remarkable perspective on the fragility of life, reality of dying, and the ethical and legal issues associated with euthanasia.

“...to die like a dog,” is an honest recollection of a woman's painful last few moments with the mother she dearly loves and her struggles to keep the family unit afloat. After passing blood for seven months and not mentioning it to anyone, not even to Leslie, who is a registered nurse, Joy Martin finds after a biopsy that she has “adeno-carcinoma of the rectum...a tumor...a cancer.” The next logical step is to perform an anterior resection, whereby, the doctor will remove the tumor and join the bowel together. The story goes back-and-forth from the hospital bed and the Martin's home. The reader is given a first hand account of Joy's sea-saw health crisis for the last

four months of her life. After finding out that Joy's cancer is terminal there is a change in the dialogue and the behavioral patterns of everyone involved. After the actual act of committing euthanasia, the reader gets an in-depth look at the role of the police/law and the way they approached such a sensitive case.

We sometimes hypothetically think of what we will do in certain situations, however, we are not certain of the course of action we will take once that hypothetical event happens to us. A death in the family has the





potential of altering mind, body, and soul. Consequentially, the choice of action is not always simple and there may be conflicts between one's moral values and the law.

Martin explains that she decided to write the book in screenplay form because her mother worked in the local theatre and was a film buff. I understand the sentimental value attached, however, I found it quite distracting and a hindrance, thus, skipping all the screenplay additives and reading it like a short essay was most effective. The screenplay format was cumbersome and unnecessary in conveying the story, which is simple and beautiful at its vital core.

What this book lacks in literary genius, it makes up in humor, compassion, and a genuine illustration of a family's love, raw emotions, and a look at the human psyche during times of trauma and distress. Throughout the book, Martin's presence is apparent, however, the presence of her siblings were partial and temporary; maybe because this book is written from her perspective. The insertion of family photos and everyday dialogue creates a unique medium for the reader. It embodies a sense of subjectivity because every family is different, yet it is objective because death is universal.

"...to die like a dog" is an easy yet poignant read. As Martin explains in the

beginning, think of it as a movie, get some popcorn, a cup of coffee, your favorite sweater and give her two hours of your time. You might emerge with a new perspective on dying, death, euthanasia, patient autonomy, and the importance of loving and living one's life to the fullest. My advice is, (1) please pay attention to your body and if something does look or feel right, that usually means something is wrong; (2) be nice to your kids and family members because they will be the ones taking care of you and you do not want to die like a dog; and (3) live your life to the fullest, such that, when death comes knocking on your door, you will be dressed and ready to be escorted out with ease and the feeling of a fulfilled life. The recent passing of a friend added a perspective of sensibility and sympathy to this book, however, this book holds its own. I can guarantee that after reading this book, you will ask yourself, what would I do in this situation?



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New Additions

New Ethics Intern

The Program welcomes our newest intern, Ruchika Mishra. She joined our ethics team in September and will be with us until next summer. Dr. Mishra has an M.A. in Health Care Ethics and she recently finished her Ph.D. in Philosophy at the University of Leeds, U.K. Her dissertation examined the ethical

issues surrounding new reproductive technologies. While at Leeds she also taught Medical Ethics and Philosophy to a diverse group of students from various academic and professional backgrounds. At CPMC she will be introduced into our busy world of clinical ethics consultation.

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