

SPRING 2005

## Commercialism in Medicine

ON FEBRUARY 11, 2005 THE PROGRAM IN MEDICINE AND HUMAN VALUES sponsored a public forum on the perennial issue of commercialism in medicine. We invited four bioethicists of national prominence to join us, Drs. Jonathan Moreno, Larry Churchill, Joseph Fins and Larry Schneiderman, respectively Professors of Medical Ethics at University of Virginia, Vanderbilt University, Weill Cornell-New York Presbyterian Hospital and University of California, San Diego. They spoke on the topic, after some considerable research and the composition of several papers, and invited comments from the audience of some 150 persons. Our findings were quite profound. Allow us to elaborate:

During the Middle Ages medical ethicists warned doctors that they would commit a mortal sin if they rejoiced that their patients were sick. Such pleasure at a patient's pain was obviously motivated, thought the ethicists, only by the vice of avarice, for more sick patients meant more business. Doctors must make a living, they acknowledged, but the desire for gain must be restrained by the dedication to the sick. Money has always been a concern of medical ethics. One medieval doctor proclaimed, "We must serve the poor free for the love of God but the rich we can make pay dearly."

In recent years, however, this issue seems to have blown up into a storm of concern. We call that concern the problem of commercialism in medicine. Commercialism means much more than the exchange of money for medical services. Medicine as a form of exchange is a kind of

commerce and has existed as long as doctors have treated patients, with its attendant virtues and vices. Commercialism is, we think, a new and unique problem.



Our speakers agreed that the term commercialism means that all activities of any realm of human activity, whether art, religion or healing, are interpreted as forms of commerce, of economic exchange. The power of financial gain subverts all other values.

Markets are not only places where money flows as investment and profit. They are also places where increasingly sophisticated messages are broadcast. The striving for market share, the clever strategies for "branding," the effort to package everything as a commodity that can be priced and redesigned and marketed—all these are part of the modern marketplace. The market is where deals are made, discounts negotiated, bonuses awarded and off-time arrangements, out of sight of consumers, can take place. The meaning of all relationships is reduced to market behavior. As one of our participants said, "Commercialism is the hegemony of money: Money becomes the single standard for value and as such drives out all other values."

How is this happening within the practice of medicine? The encounter between patient and physician is no longer a private one. It is a cubicle with open walls, surrounded by a crowd of managers, regulators, financiers, producers and lawyers required to manage the flow of money

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## Announcements

**Dr. Andereck** attended the annual meeting of the California Medical Association where he added his vote to the resolution sent to the U.S. Congress on the occasion of Congressional action in the Terri Schiavo case, "Resolved: that the California Medical Association expresses its outrage at Congress' interference with these medical decisions."

**Dr. Andereck** and **Dr. Jonsen** addressed Transplant Grand Rounds at CPMC on "Medical and Surgical Perspectives on Difficult Post-Operative Situations."

**Dr. Jonsen** presented the Ralph and Mary Lane Lecture on Catholic Social Thought at University of San Francisco. His topic was "From Mutilation to Donation: the Evolution of Catholic Doctrine on Organ Transplantation."

**Dr. Jonsen** gave Medical Grand Rounds at New York Hospital-Cornell Medical School. His lecture was entitled: "Too Little Life, Too Much Medicine: an Ancient Medical Maxim for Modern Medicine." He will deliver the same lecture at Cedars-Sinai Hospital in Los Angeles. He also gave grand rounds in Surgery at UCSF on "Professionalism & Commercialism."

**Dr. Andereck** presented Grand Rounds at St. Luke's Hospital, "Evolving Concepts of Autonomy in the ICU: Lessons Learned from the CPMC Ethics Committee."

The Program has a new Administrative Coordinator, **Mr. Antonio Kruger**. Antonio comes to us from an HIV prevention and education background as well as communications. He is a Bay Area native and a huge fan of the Giants and the 49ers. Please welcome him.

## The Terri Schiavo Case

TERRI SCHIAVO DIED ON MARCH 28, 2005, amid a maelstrom of media publicity. It might seem superfluous to say more than has been already said but, as ethicists, we cannot restrain ourselves from some comment. So much emotion, confusion, misinformation, hype and exploitation surrounded Terri's life and death that we feel some quiet reflection and some accurate information would benefit the readers of *Ethical Times*. We do not question the sincerity of those close to Terri. We wish only to put her case in the context of medical ethics and to draw some conclusion that might be useful to all of us.

The story is well known. Theresa Schiavo, age 27, married for six years to Michael Schiavo, suffered a cardiac arrest on February 25, 1990. Her brain was deprived of oxygen long enough that severe damage was done to brain cells. She was admitted to the hospital in a coma that, after some time, developed into what is called a "persistent vegetative state." She was unconscious, uncommunicative and dependant on a tube for her nutrition. She remained in that condition until she died, fifteen years later.

The first point that requires clarification is the nature of "persistent vegetative state," (PVS). There was much confusion in the media about this condition. The term designates a medical condition that follows extensive damage to cells in that part of the human brain where internal and external stimuli are processed into perceptions, sensations and understanding. The parts of the brain that manage other functions—such as breathing, digestion, and many sorts of physical movement—remain intact. It happens that, if damage is serious enough, the patient may awaken from the initial coma, which is a deep sleeplike state, to a peculiar "awakeness"—eyes open, movements are made but no signs of awareness appear. The technical description says, "patients in a persistent vegetative state are unaware of themselves or their environment. They are noncognitive, non-sentient, and incapable of conscious experience."

If this state continues for some time it is called "persistent or permanent vegetative state." The time depends upon the cause of the original injury. Neurologists usually say that a vegetative state is persistent if the patient has not recovered after three months from an injury caused by deprivation of oxygen and after a year from an injury caused by head injury, occurring in, for example, a motorcycle accident. Any recovery after these times is extremely rare and all known recoveries have been very limited, leaving the patient with severe mental and physical disability. At present, there may be some 150,000 persons in this condition in the United States. A person in PVS



Teresa Marie Schiavo, December 3, 1963 – March 31, 2005

is certainly alive but has permanently lost the most prominent human characteristics: the ability to communicate, interact consciously with others and the environment and, in all probability, to even be conscious of self.

The second crucial question concerns who makes decisions about Terri's care. In principle, Terri, as an adult, has the authority and the right to make decisions about her care and about her life. She does not, however, have the ability to make that decision, since she has lost the capacity for self-reflection and communication. It is customary in medical practice and in law that a spouse assumes that authority and, in Terri's case, a court affirmed Michael Schiavo's right. When someone makes such a decision, law and ethics require that the decision maker make the choices that he or she knows the incapacitated party would choose, if he or she has evidence of these preferences. Michael testified that Terri would not have wanted to live in the circumstances of her present existence, although he presented no evidence of these wishes, such as a written document. When this testimony was challenged by Terri's parents, Mr. and Mrs. Schindler, the matter was reviewed in several Florida courts according to the strictest standard of evidence, clear and convincing evidence, and was affirmed. Thus, the question was not whether Michael had the right to make the decision but whether Terri's decision should be honored.

Finally, Terri was certainly living (persistent vegetative state is often wrongly considered "brain death"). Her life was supported only by the methods of artificial nutrition that deliver minerals and vitamins through a tube inserted into her gut. The ethical question is whether, given the quality of her life, there is any duty to continue to provide this medical means of support. One answer to this question is that, in fact, patients in this condition have no quality of life. A person has a viable "quality of life" only if they are able to do things like evaluate, assess and compare—processes requiring some level of conscious, reflective experience. To the best of our knowledge, she did not have this. Thus, quality which, if it means anything, means better or worse experience, has disappeared from Terri's life.

In 1976, The New Jersey Supreme Court wrote poignant words about Karen Ann Quinlan, a young woman in very much the same situation as Terri Schiavo:

"If miraculously lucid for an interval...and perceptive of her irreversible condition, Karen Ann could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."

It must be noted that the complaint that Terri was starved to death is not to the point: in persistent vegetative state the pangs of hunger or

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that makes that encounter possible. All of them can look into the encounter and see opportunities for profit or economy. All would like to have a say in how the encounter goes—from the time it consumes, to the drugs it prescribes, to the costing out of each of its elements.

It is obvious that this complexity is necessary. The technology of medicine, the vast population served and the elaborate structure of the modern corporation require vast amounts of money. It is imperative that we understand precisely how this complex structure affects the encounter between physicians and patients: to know how it shapes the motives, attitudes and decisions of physicians, to appreciate how it impacts the quality of care given to patients, and to realize how equity in access and service is modified.

Everyone who watches television has seen appealing ads for this or that drug, urging you to ask your doctor whether that drug is right for you. In this way, the pharmaceutical industry comes with you into your doctor's office. This, and many other strategies, can transform the relation between you and your physician into a commercial transaction. Dr. Marcia Angell,

*SCHIAVO, continued from inside*

thirst are not experienced—nothing is experienced. Also, the “feeding” done by a tube into which a fluid mixture of minerals and vitamins can hardly be compared to the compassionate spooning of jello into the mouth of a very sick and debilitated person. It is a technical process. After it is stopped, the body's metabolism changes, leading usually to a quiet and painless death, much like the death during sleep that many people say they would prefer.

Ethicists have discussed whether it is ethically proper to discontinue artificial nutrition for patients like Terri for some thirty years. The consensus agrees that it is ethical. Even Catholic theologians have agreed, seeing nutrition as an “extraordinary” medical intervention for such patients. However, in 2004, Pope John Paul II spoke against this position, affirming that arti-

former editor-in-chief of the New England Journal of Medicine, criticizes the pharmaceutical industry in terms that describe commercialism in general. “Now primarily a marketing machine to sell drugs of dubious benefit, this industry uses its wealth and power to co-opt every institution...[including] the medical profession itself. Most of its marketing efforts are focused on influencing doctors since they must write the prescriptions.” (quoted in NYTimes, Bob Herbert, A Gift for Drug Makers, 1/14/05, A19) Does that influence work? Does it render doctors less discriminating and patients more demanding? Does it transform a medical consultation into a “marketing” opportunity?

We intend to continue this conversation throughout the CPMC community. We have had two interesting meetings with the chairpersons of major clinical departments. Our Visiting Scholar, Professor Jacob Needleman, a renown philosopher, is gathering these comments together and working them into a thoughtful reflection on the how a culture of commercialism changes the ways in which doctors view their practices and patients are treated by their doctors.

cial nutrition was an ordinary means of care and thus obligatory. Ironically, Michael Shivo's choice to discontinue nutrition conforms to the consensus of Catholic theologians; the Schindler's choice to continue follows this new position of the Pope.

These clarifications, we hope, provide a better understanding of this tragic case. The very human story was distorted by political motivations that are unlikely to happen to many of us. However, it emphasized the importance of thinking ahead about your own situation and discussing it with family, physician and spiritual advisors. The Advance Care Directive is one way to pursue such a conversation. We are planning an Advance Directive Fair for this Fall so keep watching us! We're here for you.