

# ATRIUM

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The Report of the Northwestern Medical Humanities and Bioethics Program

## HEROES AND VILLAINS

IN THIS ISSUE,  
HUMANITIES GIRL  
AND BIOETHICS BOY  
TAKE ON...

THE SIMPLIFIER



"BLACK AND WHITE AT 11:00!"

THE PUSHER



"LUNCH IS ON ME..."

THE BEAN COUNTER



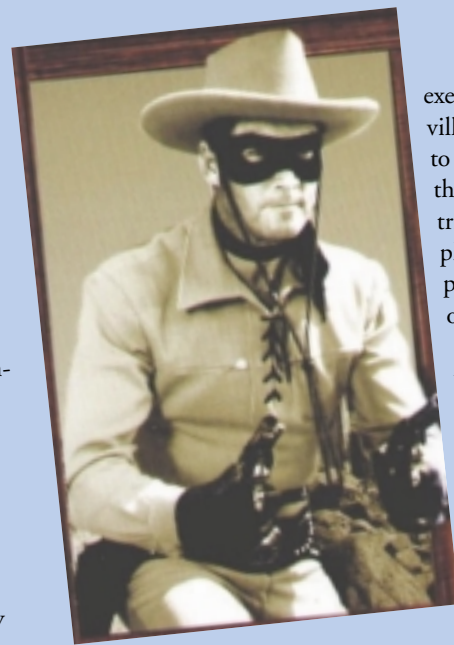
"SORRY GANG—NO MARGIN, NO MISSION."



## DEFENDING THE DICHOTOMY

Catherine Belling, PhD

Our cover is ironic, of course. Superheroes aren't people, or even representations of people. Bioethics Boy is the personification of an abstraction, the good we imagine bioethics can do in the face of maleficent forces we can animate as villains. Heroes and villains are narrative functions that structure meaning at some level in virtually all stories, aspects of a single complex self—the reader or listener. The hero is an ideal, a collection of desirable character traits, a paragon. The villain is the necessary opposite against which the hero is defined. From Jack on his beanstalk through Superman to Clarice Starling—and the Giant, Lex Luthor, and Hannibal Lecter—heroes and villains allow us to identify with and aspire to the good even while we sometimes secretly admire the seductively wicked. Nuance, ambiguity, and moral complexity don't



exemplify superheroes; true villains have no back-stories to explain their excesses. But this does not mean they are trivial or childish oversimplifications. Their lasting power should warn us otherwise.

Medicine still functions largely according to a combat analogy where the villain is disease or, most fundamentally, death. Patients are victims to be rescued, and physicians embrace the persona of hero. In many cases this is just as it

should be, surely just as the patient would like it to be. And yet at present many disapprove of "heroic measures" when treating patients. Staving off death at all costs is warned against as hubristic excess. These days, we expect our aspiring hero to rein in his superpowers and ask permission, in case the damsel really wants to ride off into the sunset on the arm of the dragon, or live safely forever in some cozy dungeon. These days, the hero is seldom sure that he (or she) is a hero. Maybe, he worries, I'm just the protagonist in a postmodern faux quest for illusory narrative closure.

The real paradox of our cover is that the rise of bioethics helped deconstruct medicine's traditional hero-villain dichotomy, stripping doctors of their confident white-coat-capes and arming patients with the powers of their erstwhile rescuers: access to information and the ability to make decisions. Patient autonomy, the choice to consent to rescue efforts—or to refuse and send the hero aimlessly (or relievedly) on his way—is inseparable from a more accurate but nonetheless disillusioned view of physicians as fallible and medicine as uncertain.

Humanities Girl may be heading for an identity crisis since the source of her power is also what renders her indecisive. Narrative ethics explores shades of moral meaning, recognizing that the heroes and villains in stories are situated, contingent, and dependent on the point of view of the narrator. This ethics assumes more than one story, more than one perspective. Thick description complicates and ambiguates unnuanced archetypes of good and evil. But narrative itself—in any single accounting of events—relies first on reducing the world to what makes meaning in the story, to forces in conflict. Convert any experience into a story and the roles begin to emerge, one way or another, because they are necessary to the work narrative does. Stories make moral meaning: what is good? What is bad? Although different accounts of the same events make different meanings, we should not discount the importance and usefulness of assigning the roles of hero and villain within any single telling. We need these distinctions as poles to guide our navigation of all-too-gray reality.

Faced with the risks of relativism and abdicated responsibility, medicine could do worse than to turn at times to characters—characters, fictions, not real people—that signify what we value and what we abhor. Through them, we can see more clearly what it is we already believe in. Then we can complicate things.

The MH&B Program thanks illustrator Kevin Cuasay (kcuasay@gmail.com, www.endlessbowl.com) for the original work he created for this issue's cover. **KAPOW!**

## DISINTERESTED COMMITMENT AS MORAL HEROISM

Charles L. Bosk, PhD

Bioethicists have become prominent as the public face of medicine's struggles around ethical issues. The media typically portray these conflicts as Titanic, dyadic struggles that bring into play organized political interests, public values, and fundamental principles of social order. Public narratives are fashioned that reduce complex, existential dilemmas to the logic of the lowest common denominator—good versus evil, progressive versus backward-looking, open and tolerant versus closed and bigoted, provincial and particularistic versus global and universalistic.

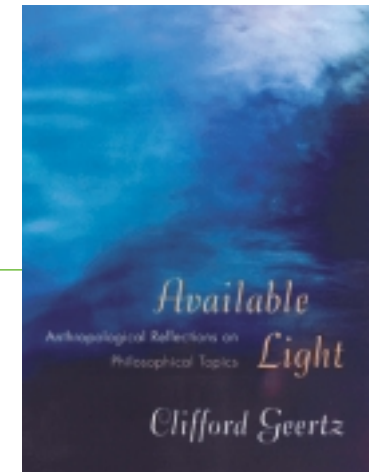
As these narrative frames emerge, bioethicists become "heroes" for those championing one position and "villains" for those on the other side of the issue. I have no trouble understanding why the media frame issues so that, however multi-dimensional they are in reality, they are presented as appearing to have only two sides. However, heroes-and-villains narratives for understanding bioethical issues—or for that matter, any other complex problem—possess the potential for preventing rather than promoting civil discourse, a respect for pluralism in the public arena, and sound public policy.

As an ethnographer of the culture of medicine, I have both a learned incapacity and a visceral distaste for thinking in terms of "heroes and villains." In fact, much of my work has been aimed at undoing the interpretive oversimplifications created by blunt analyses of medical settings that characterize physicians as villains who exploit patients' pain and suffering for profit, patients as passive victims who are unable to exercise authentic choice, and ethnographers as heroes who have the moral courage to speak the truth to power.

### Rejecting hero/villain dichotomies

In *Available Light* (Princeton University Press 2000), anthropologist Clifford Geertz describes his essay, "Passage and Accident: A Life of Learning," as an attempt at a literary genre with which he has never experimented—*bildungsroman* as auto-obituary. Of what can hardly be described as an unexamined life, Geertz says, "A lot of people don't quite know where they are going, I suppose; but I don't even know, for certain, where I have been." Geertz's humble, candid yet evasive, 'I stumbled here, then there, and somehow landed on my feet' characterization of himself permits us to see as heroic his search in distant places for local knowledge that leads to more global understanding.

However uncertain Geertz claimed to be about his location in his life's changing 'here and there,' he was steadfast in his calling as a cultural anthropologist, a calling that for him involved preserving, extending, and, on occasion, proselytizing for an alternative to the ever more scientific



"Who are these people? What do they think they are doing? To what end are they doing it? In what frames of meaning do they enact their lives?"

agenda regnant in the social sciences. Operationally, his work involved using the five senses nature provides us, and employing the modest technologies of paper, pen and portable typewriter for recording and organizing data in field notebooks in order to understand what was going on in whatever "here" he happened to find himself.

The Other against which Geertz struggled—more an opposing point of view than a villain—the other that not so much must not be named but, rather, lacks an adequate one, is the plurality of approaches to studying social life that reduces the troublesome business of being human, living among other humans, to universal rules independent

of the particularities of time and place

or to the influence of structural forces. Such approaches reduce all the social *fictios* that we create and use in sustaining a shared collective life to a trivial matter. Geertz resisted attempts to explain social life through what he dismissed as "laws and causes" sociology divorced from everyday lived experience. While he was both prolix and prolific in his advocacy for approaches to social life that gave primacy to native understandings, he, nonetheless, paid the highest compliment to those

who found themselves on the other side of the argument. He approached them as he would any group whose beliefs and practices were radically different from his own. He struggled to understand how they had "hung themselves in webs of significance that they themselves had spun."

I start this brief commentary on heroes and villains in bioethics by invoking Geertz because his life and work touched and changed mine, and because when Geertz tells

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Geertz photo reprinted with permission from the *Annual Review of Anthropology*, Volume 31 ©2002 by Annual Reviews

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us that he is certain neither about where he is going nor where he has been, he invokes for me an image of what heroism looks like for the social scientist. To strike a balance between disinterest and commitment, to look at social life as it is lived without the crutch of either an operational proceduralism or a fixed theoretical template that determines even before it is gathered how data will be interpreted requires an extraordinary amount of intellectual control, willpower, and energy.

This is not to say Geertz in particular, or fieldworkers more generally, enter the field as empty vessels with no conceptual frameworks to draw upon and no moral commitments. Idle curiosity alone is not sufficient cause to leave the comfort of one's cloister, propel one halfway

across the globe, and sustain the strange experience of living so absolutely alone among others. The questions we ask are usually provoked by a very intense normative itch, our observations and analyses nothing more than a constant scratching of the social skin of others. Geertz's heroism as a social scientist involved a resistance to accepting one's home truths as "natural, universal, or transcendently rational," a delight in ambiguity, a joy in the discovery of the multitudinous ways groups express their humanity, and the uncanny ability to be deadly serious and mordantly humorous about both himself and his attempts to make sense of others.

The peculiar marriage of intensity with detachment that characterizes Geertz's work reminds us to be wary of unshakeable certainty. His thick description of unfamiliar social worlds reminds us that nothing unsettles one's settled convictions so much as a close look at the settled convictions of others. Such looking involves suspending judgments of all sorts, especially judgments about who are heroes and who villains. Before making judgments, one needs to know what is going on here—an issue bewilderingly mysterious to the uninitiated and, more frequently than one might imagine, to the initiated. The human condition involves making choices in an open-textured field in the confusing instant of what philosopher G.H. Mead described as "the knife-edged present." The meaning of what just happened becomes more or less clear depending upon what happens next and next as experience gets piled upon experience. What we were certain was virtuous may prove, in time, to be the opposite. Intentions matter, but then so do consequences.

I have always had different analytic goals than passing judgment on who is a hero and who a villain. These goals align neatly with those Geertz saw as critical to ethnographic analysis, goals which he articulated more gracefully than I am able. So, once again I allow him to speak: "The study of other people's culture... involves discovering who they think they are, what they think they are doing, and to what end they think they are doing it..." Geertz then adds, "To discover who people think they are, what they think they are doing, and to what end they think they are doing it, it is necessary to gain a working familiarity with the frames of meaning within which they enact their lives... It involves learning how, as a being from elsewhere with a world of one's own, to live with them."

These questions—Who are these people? What do they think they are doing? To what end are they doing it? In what frames of meaning do they enact their lives?—are crucial for understanding the conduct of all those involved in health care. The questions have a heightened urgency as choices about stem cell research, global health disparities, and emerging pandemics occupy both health professionals and public officials. This urgency stems from the fact that the fundamental Weberian questions for which science is unable to provide an answer—Whether simply because we can master life technically, we ought to do so?—demand immediate answers. The pace of events press new confusions upon us at a rate that exceeds our collective ability to think about them in other than deeply reductionistic, oversimplifying ways that efface the particularities of time and place.

## The rise of bioethicists

Only recently have self-appointed experts been willing to step forward and pronounce on those questions about which science is silent. However "natural" it appears, the emergence of this new group of experts at once both professional and political, present both at the bedside as clinical ethics consultants and at legislative hearings as policy advocates, is a cultural and social development that requires analysis. For the social scientist, the emergence of a new body of experts willing to lift the burden of the most weighty of human condition questions from our collective shoulders, willing to provide answers to problems that might otherwise trouble our sleep, is a phenomenon that provokes a profound sense of wonder.

When we pay close attention to the questions upon which professional ethics experts expatiate, our sense of wonder is amplified: What, if any, interventions in the clinic and in the laboratory with the basic state or stuff of being human are prohibited? Are there limits to our inclination to tinker with ourselves upon which we can agree? Or is the mere whisper of limits a denial of our basic human nature, some hard-wired striving to understand and enhance our selves and the world? If we look at the disproportionate focus of ethics experts on rare clinical occurrences or hypothetical future advances and the relatively perfunctory notice of the horrifying inequities in both access to health care and to other public goods—adequate education, housing and nutrition—in locales near and distant, Geertz's core ethnographic questions—Who are these people? What do they think they are doing? To what end? Within what frames of meaning?—become all the more urgent.

These questions resist a simple answer. Bioethics is a plural noun in at least two different senses. First, the community of bioethicists is hard to bound. There is no sensible way to draw a line that separates the legitimate expert from the imposter. Ethics expertise is claimed on many grounds by many people: a long experiential base grappling with clinical issues at the bedside, a prescient awareness based on active involvement in cutting-edge science that allows one to foresee implications of advances in the laboratory, the mastery of a body of philosophical, legal or social scientific knowledge, service as a public official charged with carrying out contradictory policy directives, personal experience as a patient, as well as fidelity to a faith-based tradition lists only the most typical bases upon which moral authority is grounded. Second, under the rubric "bioethics" a variety of socially visible activities is collected: teaching, research, policy-making and enforcement, consultation to industry, public advocacy, mediation of conflict at the bedside, and media punditry is a partial list.

However plural the collectivity of people who claim expertise as ethicists and the arenas of action in which they attempt to exercise their putative authority, one frame of meaning dominates the public understanding of the collection of the activities that comprise bioethics: ethics as conflict. Knotty dilemmas of research ethics; the rights of the unborn, the living, or the dying; advocacy in public arenas for policy change—all are filtered through frames of meaning that see ethical dilemmas as a contest between adversaries. This framing encourages a view in which the various contending parties are likely to move quickly from

considering themselves as adversaries to seeing themselves as heroes and those who oppose them as villains. The conflict view of ethical dilemmas encourages rhetorical inflation and demonizing of the opposition. In addition, ethics as conflict makes a resting place hard to find. Combatants simply go to their corners between rounds and wait for the bell to ring, at which point they begin again to flail at each other.

To a degree the conflict frame—the manner in which ethical disputes are understood as two-sided affairs, with each side seeing itself as heroic and those who oppose it



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as villainous—appears natural in three ways: (1) as an historical artifact, especially if one views bioethics as an extension of the civil rights movement, (2) as a cultural framing, especially if one recognizes how much bioethics is grounded in the individualism of American culture, and (3) as a dramaturgical tool for communicating complex issues within familiar discourse packages through public media. However tempting it is for those involved in disputes or those reporting on them to provide heroes-and-villains narratives, and however tempting, and even emotionally gratifying, it is for us as a public audience to adopt this frame as well and root for our side and vilify the other, there are forbiddingly high transaction costs to understanding bioethical dilemmas in this manner.

I will comment briefly on three. The first of these is that the conflict frame of interpretation contributes to those forces exacerbating polarization in American society. The conflict frame not only increases polarization, it also plays a role in decreasing civil discourse. As a result, the most complex human condition problems and the deepest of existential mysteries are presented in terms that grow coarser and more vulgar the longer the issues remain in the public arena. The conflict frame possesses a dramatic momentum of its own. Heroes and villains are two-dimensional figures in most conventional narrative genres. As recognizable figures, they need few words to communicate their virtue or wickedness to an audience familiar with the larger story. Beyond that, the practices of the media contribute to the over-simplified understanding of complex dilemmas. The principle of "balance" demands two sides for each issue. Extremity creates the dramatic tension that makes for a more lively and entertaining media spectacle while satisfying the requirements of balance and fairness. The excluded middle is not just a law of logic; it also organizes the presentation of issues in public media.

A second cost of the conflict frame is that it deadens our ethical imagination in numerous ways. This frame encourages us to think of ethical dilemmas as involving choosing between a clear right and wrong. Resolutions are

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good or bad. For most ethical problems, this is a confusing distortion. What creates an ethical dilemma is the absence of good options. Ethical problems are forced upon us by the need to choose the lesser of two evils when we are uncertain which of our options is that lesser evil.

One reason that ethical dilemmas fit so easily into a conflict frame is simply that in medicine the “ethical” is made visible by an underlying social conflict between parties struggling to control the definition of the situation. When social problems disguise themselves as ethical dramas, the false promise of easy resolution enters the conflict frame. Once the struggle to define the situation is resolved, then appropriate decision maker and decision click into place. But when we frame ethical conflict as the struggle among social actors and interests, then the conflict frame works to blunt our ability to see our own internal ethical conflicts. All who work in medical settings face clinical dilemmas that create considerable internal angst. The organization of clinical ethics, designed as it is to resolve conflicts among contending parties, gives short shrift to situations in which individuals find themselves torn between two equally powerful moral imperatives, each of which tugs in the opposite direction.

Ethics consultation is organized to meet those situations in which social conflict has created decision-making paralysis. In policy domains, a similar dynamic plays out. We argue in the conflict frame about one issue at a time. Little attention is paid to conflicts between different policies or to the unintended ethical consequences that following this policy here may have on achieving those policy goals there. Finally, the conflict frame has the unfortunate

consequence of allowing us to assume that those things we do to which there is no obvious opposition are ethical. The absence of conflict induces an ethical complacency, a slackness of analytic inspection, about policies, practices, and procedures that are quotidian.

The third cost of the conflict frame is easier to describe than label. A conflict frame encourages the parties to take themselves seriously as heroes and to see those who oppose them as either innocently mistaken or purposefully wicked. Conflict often creates a chasm that makes it harder for those in a high stakes dispute over fundamental principles to recognize their common interests and humanity. Behind this loss of perspective about the character of the Noble Opposition as the rhetoric over principles heats up is a second more tragic loss: combatants in a heated bioethical dispute over fundamental principles face the very real danger of losing sight of the human beings over whose bodies these battles are being fought.

In that case, the battle between heroes and villains in the conflict frame creates martyrs and victims. When this happens, we have neither heroes nor villains. Instead, we have a society in which contest over ethical matters has made us all losers, if only because instead of enhancing our ability to see the humanity of the other it degrades that capacity. Absorbed in conflict, we forget to ask of those who oppose our definition of the right and true: Who are these people? What do they think they are doing? To what ends? Within what frames of meaning?

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# Villains and Victims

*Ruby Roy, MD*

I became a child abuse physician fifteen years ago because there was a need, and I was attracted to the challenge. All physicians are required by law to diagnose and report child abuse, but most dread these cases. I thought the skills I would gain by specializing in this difficult work would make me a better doctor for all my patients. What I learned was that the legal focus of the child abuse role compromises any meaningful doctor-patient relationship, and my longing for that relationship is part of the reason I’m leaving the specialty.

When I do a child abuse consultation I am not taking care of the child, at least not by the usual definition of medicine. I do a physical exam to verify injuries and their patterns, not to treat or cure. Any pediatrician interviewing parents must establish rapport to get an accurate story, but I do it without the confidentiality of a classical doctor-patient relationship. If there’s trust, it’s misplaced, because I take a history to evaluate whether the family is telling the truth about the injury. My diagnosis is a socio-legal one: whether the injury is accidental (and if so, whether the accident is the result of negligence), or whether it was inflicted by child abuse.

One day I joined my intern toward the end of the kindergarten check-up of a five year old I’ll call America. I could tell Kate was charmed by this girl who had drawn a picture “for her doctor,” and because she assumed America was an average child, she didn’t check the beginning of the chart. If she had, she would have seen the notes from the first child abuse consultation I ever did. When America was one month old, she was hospitalized for cerebral hemorrhage and multiple fractures to the skull, ribs, and legs, and I testified in her case.

Five years later, I’m startled to see America’s mother here with my intern. She and her husband were educated people who “lawyered up” immediately and claimed no knowledge of any injury. Child protective services called for a custody hearing because no accident explained America’s injuries, and fractures have no fingerprints. Without knowing the guilty party, CPS couldn’t return this baby to either parent.

I was a general pediatrician barely five months out of training when America’s case went to court. I was also weeks away from becoming a mother myself. I felt massive, exhausted, and worried that my lack of experience would make it easy for the lawyers to challenge my expertise.

The defense lawyer turned out to be as young and inexperienced as I was. He based his argument that all the injuries were caused by obstetrical malpractice on the kind of handbook carried by residents and students, except his was outdated. Our neurosurgical and orthopedics physicians did everything they could to avoid going to court, so I had to shoulder the entire responsibility for making the case for abuse.

I avoided America’s mother’s eyes in that small courtroom. I had a hunch she wasn’t the abuser, and I wondered who she was protecting and why. I successfully made the case for the state. Then I had my own baby, haunted by the thought that this mother would lose hers.

Five years later, as I watch my intern examine this beautiful child, I am uncertain if her mother remembers me. I nod to her briefly as we silently watch this seemingly normal check up. Kate counsels about car seats and dentists as I flip through the chart surreptitiously. I find a brief note scrawled by a social worker at the six-month visit: “mother divorced father of baby, history of domestic violence and suspected child abuse. Court clears mother, full custody, no visitation by father.”

As Kate concludes, the mother interrupts: “Dr. Roy, did you have a boy or a girl?” I tell her my son is due for his kindergarten visit too, he’s just one month younger than America. We smile at each other, and she thanks me. This time, I am able to look her in the eye.

This moment represents all I hoped to accomplish in this work. It’s rare for child abuse physicians to see the long-term results of their work; the lack of tangible evidence of our efficacy may be why many physicians avoid it.

It was also the only time in fifteen years a parent thanked me. The thankless nature of our job means we consider ourselves unsung heroes. The children are too young to be grateful, and our colleagues are busy

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Illustration: Jillian Evans, age 5



struggling with these cases also. They struggle with the trauma of the case itself and have to interact professionally with family members who may have either caused the abuse or condoned it. As treating physicians, they may bear an extraordinary responsibility when their medical decision-making can make the difference between a charge of child abuse and murder.

Yet sometimes I think that other physicians are the people the child abuse physician is actually treating in this complex set of relationships. In pediatrics the child is typically viewed and treated as part of the family unit. Suspicion of child abuse can divide a child from their parents, so dividing the medical role allows the treating physician to preserve their relationship to the family. My existence liberates them from the stress of going to court, and frees the time and emotional energy they need to take traditional medical care of the child.

Evaluating the child and family in this consultative role—as a liaison between the medical and legal systems for the physicians who actually treat the child—makes it easy for child abuse physicians to divide ourselves from parents. It's not only easy, in some ways it's necessary for us to consider them inhuman villains. Because one way to sustain yourself in a difficult, thankless job is to quietly supply your own reward. Private fantasies of heroism are nourishing, and it's hard to feel heroic without a villain. Compassion for humanity is the reason I became a physician. Yet compassion for parents' humanity may rob child abuse physicians of the inner resource that's getting us through the day.

One of my last child abuse consultations involved a mother I'll call Brenda. Honestly, I can't remember her real name, despite—or perhaps because of—her tremendous impact on me. We were two dark-skinned women of small size and build, so similar, yet from totally different worlds. I tell her I am a pediatrician with the “child advocacy team,” I don't use the word “abuse.” I tell her I'm here to “listen to her story,” I don't tell her I will functionally be doing a legal interrogation, and it would probably be in her best interest to get a lawyer before she talks with me. I suspect this mother does not comprehend what I have not said, because she lets down her guard as she talks.

Brenda is twenty-one years old, the single mother of two children by different fathers. Now she is pregnant a third time, the result of a brutal rape. Since this trauma, she has been haunted by fear, flashbacks, and depression, and she worries about her

ability to care for the new baby. I appear compassionate, but I'm not here to take care of her. I'm here because her three-year-old daughter, whom I'll call Jenny, is lying in Intensive Care, silent, desolate, and brutally beaten.

It isn't really my job to “take care of” Jenny either—that's what the intensivist and trauma surgeon are doing. As the child abuse consultant, my job is to find the truth behind her bruises, fractures, and abdominal injuries. Suspicion centers on Mom's current boyfriend, recently released from jail for armed robbery. But when I place my hand on Jenny's back, her bruises line up perfectly under my small fingers, fingers like those of the woman who is now opening up to me.

Jenny's mother tells me about the abuse and neglect she endured at the hands of her own alcohol- and drug-addicted mother. She tells me of becoming a ward of the state in her teens, moving from foster home to foster home, where her abuse often continued. She was still a ward when she became pregnant by her first boyfriend, a man eight years her senior who fostered her drug habit. I sit in silence, listening. She pauses often and repeats sentences. She has been up all night since her daughter was brought in to the hospital. She fixates on her own mother. “I'm just like her,” she says. “She beat me and I became just like her.”

I am not surprised when the detective calls to tell me that the mother confessed the next day. In exquisitely painful detail, Brenda described how she repeatedly threw her daughter across the room; how she heard bones crack as Jenny hit the far wall. How she pummeled Jenny's abdomen with her fists, how she continued to slap her after Jenny lost consciousness. Like her mother before her, now Jenny is a ward of the state. Brenda is in jail, she will lose all her children, and the detective is pleased—my consult helped focus his questioning, and because the mother referred to me during the confession, he credits me with setting the stage for her to talk.

I accomplished my goal in this case: I protected Jenny from future harm by identifying abuse and the abuser. But what happens after that? If I could view Brenda as a villainous criminal, it'd be easy to do this work. Seeing her as a victim of the system, as a woman in need of psychiatric treatment and drug rehabilitation, makes my role more problematic. Will Brenda remember me as a physician who betrayed her trust? Or as the woman who provided an outlet for her story when she was horrified, guilt-ridden, and needed someone to tell? Will Jenny receive enough psychological care and support so that she won't grow up to beat her own children? Or does saving Jenny's life also perpetuate her family's cycle of poverty, drug abuse, and violence?

After fifteen years I'm leaving this work, but I will never leave its questions. I'll continue to struggle to understand a role Hippocrates never dreamed of, one where heroes are sometimes villains, abusers are sometimes victims, and physicians don't feel like physicians anymore.

*Ruby Roy is a general academic pediatrician who recently joined the Neiswanger Institute for Bioethics and Health Policy and began teaching medical humanities at the Stritch School of Medicine, Loyola University Chicago.*

*I'll continue to struggle to understand a role  
Hippocrates never dreamed of, one where heroes are  
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## Villains and Saints: Dietrich Bonhoeffer's Ethics

Nancy Berlinger, PhD

A few years ago, while I was researching and writing a book about the ethical dimensions of harmful medical mistakes, I turned to the works of theologian Dietrich Bonhoeffer for insights into the nature of truth-telling, and for cautions against the shoddy ethics of a “cheap grace” that automatically forgives mistakes without attention to their consequences.<sup>1</sup> I've found that physicians who have never heard of Bonhoeffer get him immediately. They've seen cheap grace in action, whenever a hospital proclaims itself a blame-free culture without explaining how, exactly, this tectonic cultural shift is going to happen. They've seen it when colleagues offer one another absolution for mistakes—to err is human, stuff happens—without finding out why it happened, and what the consequences were for the patient, to whom this also happened. Bonhoeffer's identification of the perspective of “those who suffer” as the indispensable starting place for ethical reflection and ethical action makes sense to physicians and others who work in systems whose goal is the relief of suffering.<sup>2</sup> Even physicians in specialties where lawsuits are frequent, and who may lapse into the familiar adversarial shorthand—“those angry families”—when discussing mistakes, can identify the injured patient and his or her family as those who suffer most from medical harm, and whose suffering must be attended to first.

It's the theologians who are surprised that Bonhoeffer works in the clinical setting. This may say more about how theologians view the relevance of their own discipline than it says about Bonhoeffer, whose favorite adjective may have been “concrete” and whose preferred noun, at least when writing of ethics, was “responsibility.” As he wrote in a remarkable letter, a New Year's gift to his colleagues in the German anti-Nazi resistance in 1943:

The ultimate question for a responsible man to ask is not how he is to extricate himself heroically from the affair, but how the coming generation is to live. It is only from this question, with its responsibility toward history, that fruitful solutions can come, even if for the time being they are very humiliating. In short, it is much easier to see a thing through from the point of view of abstract principle than from that of concrete responsibility.<sup>3</sup>

The date of this letter hints at the sort of “thing” Bonhoeffer is thinking about and trying to see through. In 1940, he had begun drafting a major work on ethics. In an early manuscript, he writes that his generation didn't seem at all interested in ethical theory, because they were living under “pressure of a reality filled with concrete, ethical problems”:

Today we have villains and saints again, in full public view... Shakespeare's characters are among us. The

*(continued on next page)*



Dietrich Bonhoeffer (1906-1945)

**He mistrusts the ethics of the saint, the hero, and the martyr—the saint who withdraws into “private virtuousness”; the hero who will not risk humiliation; the martyr whose individual self-sacrifice changes nothing.**

**These, for Bonhoeffer, are self-regarding modes that do not help those who suffer.**



# The Few & the Proud

villain and the saint have little or nothing to do with ethical programs.... Those who are committed to an ethical agenda are compelled to a serious waste of their energies.<sup>4</sup>

In 1939, Bonhoeffer had returned to Germany after spending six weeks in New York City. He had studied at Union Theological Seminary in the early 1930s, and colleagues in the United States (Reinhold Niebuhr in particular) had invited him to take part in various projects, in the hope of keeping him from being called up for military service—and executed as a conscientious objector—if he remained in Germany during the coming war. Almost as soon as he had landed in New York, Bonhoeffer suspected he had made a mistake. He spent six weeks chain-smoking in the “prophets’ chamber,” Union’s guest room for visiting lecturers, overlooking Broadway and 121st Street. (The room, minus cigarette butts, contains Bonhoeffer memorabilia and can be visited today.) He then wrote a letter to Niebuhr, his mentor and friend, explaining, “I have made a mistake in coming to America,” and that he had to go back, as “I will have no right to participate in the reconstruction” of his nation if he did not live through its destruction along with everyone else.<sup>5</sup> And he sailed home, arriving back in Berlin a month before the war began, and resumed his work with Christian pastors and churches struggling to oppose the Nazi regime. Within a few months he had also joined the “generals’ plot” to overthrow the regime by assassinating Hitler himself. His cover, ironically enough for a pacifist, was a position in the *Abwehr*, the military-intelligence office that was a center of anti-Nazi conspiracy.

*While he was writing to condemn the evils of his own historical moment, he was also writing for the restoration of civil society, for the time beyond “villains and saints”....*

When he began to write his *Ethics* (he worked on it continuously throughout the last five years of his life) Bonhoeffer was writing to keep a clear head—if not a clean conscience—amid villains, parsing the ethics of concrete resistance to concrete evil. He mistrusts the ethics of the saint, the hero, and the martyr—the saint who withdraws into “private virtuousness”; the hero who will not risk humiliation; the martyr whose individual self-sacrifice changes nothing. These, for Bonhoeffer, are self-regarding modes that do not help those who suffer. (More irony: Bonhoeffer himself has long been characterized as a hero, a martyr, or a Protestant saint.) He mistrusts these as effective ways of confronting present evils, and as constructive ways of rebuilding civil society and its religious and cultural institutions. His *Ethics* is an attempt to grapple with normal as well as abnormal ethical problems, to begin to set an ethical agenda for a time when attempting to define and

live within the rules will no longer be a waste of energy. When the nation is run by villains, by transgressors, the responsible person, the patriot, is forced to become one as well. At least, this was the choice as it presented itself to Bonhoeffer in 1939: join the struggle against present evil, and think and write your way into your nation’s future. Bonhoeffer did not live to see that future. He was imprisoned by the Nazis in 1943 and continued to work on his *Ethics* amid interrogations and increasingly harsh conditions. He was hanged on April 9, 1945, at the age of 39. He nearly made it, but not quite.

In ethics, politics, and other disciplines, it is not uncommon to criticize those who “play the Nazi card,” seeking to bolster their arguments through imprecise or inflammatory analogies to Nazi-era atrocities. Yet Bonhoeffer was up against the real thing: His critique of Kant’s “murderer at the door” truth-telling problem was drawn from his experience with real murderers really at the door, really after the friends you were hiding. While he was writing to condemn the evils of his own historical moment, he was also writing for the restoration of civil society, for the time beyond “villains and saints,” for the time when ethical theory could guide the normal activities of responsible citizens. And so I find him a good companion for medical ethicists working on, for example, getting professional ethics beyond “villains and saints” paradigms and figuring out how to integrate the imperfect individual professional into the ethical programs of imperfect organizations. What, exactly, is this individual’s concrete responsibility toward those who suffer? What, exactly, is this system’s concrete responsibility? And how is the “coming generation”—of patients, of clinicians, of citizens—to live? These were Bonhoeffer’s questions, and now they are ours.

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A new scholarly edition of Bonhoeffer’s *Ethics* (Fortress Press, 2005) has been published as part of the ongoing *Dietrich Bonhoeffer Works translation project*.

<sup>1</sup> Dietrich Bonhoeffer, *Discipleship*, Dietrich Bonhoeffer Works, Volume 4, Ed. G. B. Kelly and J. D. Godsey. Minneapolis: Fortress Press, 2001, 43.

<sup>2</sup> Dietrich Bonhoeffer, “After Ten Years,” in *Letters and papers from prison*. Enlarged ed. Ed. E. Bethge. Trans. R. Fuller and F. Clark. New York: Simon and Schuster/Touchstone Books, 1997; 1-17, at 17.

<sup>3</sup> Bonhoeffer, “After Ten Years,” in *Letters and papers from prison*, 7.

<sup>4</sup> Dietrich Bonhoeffer, “Ethics as Formation,” in *Ethics*, Dietrich Bonhoeffer Works, Volume 6, English edition ed. C. J. Green. Trans. R. Krauss, C. C. West, and D.W. Stott. Minneapolis: Fortress Press, 2005, 76-77.

<sup>5</sup> Eberhard Bethge, *Dietrich Bonhoeffer*. Revised ed. V. Barnett. Minneapolis: Fortress Press, 2000, 655.

Gretchen Case, PhD

My seven-year-old nephew, a prolific consumer of fictional heroic narratives, tells me that a hero is “someone who helps people and has special powers.” Upon further questioning, he reassures me that ordinary people without special powers can be heroes, too—like when they help the endangered tigers that he adores.

Every hero has a cause. My interest in ordinary people as heroes was piqued by an ad I recently saw on the El: “The Few. The Proud. The Egg Donors.” Under this tagline three attractive women of varied ethnicity stand in a V-formation, shoulders back and eyes forward. This poster recruiting young women to donate eggs at a Chicago fertility clinic imitates the longtime recruiting campaign of the U.S. Marines. A quick search of Marine materials produces a photograph of similarly young, attractive, ethnically diverse people standing in that same V-formation.

What does it mean when an advertisement for egg donation mimics the language and visual imagery of the military? This is not an idle question in a time of war; I can’t help but analyze.

“The few.” Potential egg donors are joining an elite group to which not all who apply are admitted. Like a Marine recruit, an egg donor must exceed strict exclusionary criteria for physical and mental fitness. The text of the ad asserts that the founder and staff at this particular Chicago clinic have all donated eggs. These women have passed the entrance requirements and persevered through the rigors of their assigned mission: the production and harvest of eggs. They’re fully vested in a sorority based on the experience of egg donation, and they offer membership only to those women who are similarly capable. In other words, the recruiters are Marines too. The lure is not only to be chosen from among many to perform extraordinary acts, but also to be revealed to have special and superlative powers of reproduction.

“The proud.” The non-commercial aspects of egg donation are emphasized, the \$7,000 remuneration downplayed. To simply donate eggs in return for money raises uncomfortable questions of selling body parts, and suggests that the egg is just another body part rather than a specially-endowed cell with half the necessary material for conceiving a human being. Instead, the argument implicit in the ad is that an egg donor

is not just “donating” a cell, she is donating the potential for offspring to women who lack the full power of reproduction. The egg donor is helping people (to bear children, create families, fulfill specific ideas of parenthood) using her special powers—just as my nephew said.

“The egg donor.” Replacing “The Marines” in the original composition in both word and image, the egg donor steps into formation with others of her kind and gazes out, chin up, at those people she has helped with her special powers. She is one of a select few allowed to perform these challenging acts of bravery and selflessness, and she’s done it because she believes her sacrifice worthy. She protects and defends an important ideal: that every woman can bear a child.



Photo: Andrew Huff

The rhetorical strategy of connecting the act of egg donation to heroism, and in particular military heroism, promotes the idea that egg donors are acting with more than mere human kindness. An exceptional commitment is necessary to do the work at hand here. Marines are considered elite among the armed forces because of their frequent positioning in the first wave of a military offensive. Perhaps egg donors are meant to be the elite among maternal bodies: performing the front-line tasks, accepting risks to self in order to serve the greater good. Both military service and motherhood are often considered sacrosanct and crucial roles, but only particular kinds of bodies can perform these roles. The limited supply of appropriate bodies leads to a need for persuasion. And, albeit for different reasons, neither the fertility clinic nor the Marines can offer enough money to rely on compensation alone as persuasion. So they attempt to create and confer the social capital of heroism as well. If you join us, you transform. If you join us, you become a hero.

Other campaigns for organ and tissue donation invoke the concept of heroism, although the language and imagery typically are less direct. One donor registry, which uses photographs of average Chicago citizens rather than professional models, proclaims: “Everyone, no matter how young or old, can be a lifesaver by choosing to be an organ and tissue donor.” A donor campaign for a Nebraska transplant program uses the slogan “Be a Hero for Life.” The “gift of life” referenced by transplant campaigns is really the gift of *sustaining* life. In the case of egg donation, the gift is the potential to *create* life. One “hero” prevents death, the other allows life to begin.

The call to be a hero can be hard to resist. Heroes are rewarded in many ways: with praise, medals, a valorized

place in history, a privileged place in an afterlife, or feelings of pride and altruism in the here-and-now. The call to be a hero can also be hard to avoid, especially in times when a society is running short of bodies willing to meet specific risks. If volunteers are to be enticed, the social capital that accompanies the status of hero must be presented as being of greater value than any other sort of compensation. Few people are admitted to the ranks of the heroes, a select group that performs deeds beyond altruism. A hero must not only be unselfish and undesiring of reward, but also be ready to chance actual harm for the sake of others.

Saving nations, saving lives, saving fertility, even saving tigers: when society deems a deed “heroic,” those who do it get to feel super-human.

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# Doctor versus Patient: Pain Mismanagement in the ED

Jay Baruch, MD

*“The emergency room used to be the worst part of my going to the hospital; the nurses didn’t understand, the doctors didn’t understand, they do all this questioning. They wanted to know why the medication was not working? Why you are still in pain? If you’re crying, why you are crying; if you are not crying, how can you be in pain? If you are laughing or talking, it is mental...you are not only experiencing your pain—the crises you are going through—but you are experiencing other peoples’ opinions and feelings; that makes it worse...”<sup>1</sup>*

Pain is universally under-treated. Inadequate pain treatment, termed oligoanalgesia, is so widespread that in 2001 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) declared it a public health problem.<sup>2</sup> The general medical community has offered several explanations—worries about liability and regulatory sanctions, fears of turning patients into addicts, concerns about drug diversion, and insufficient knowledge about pain and pain treatment<sup>3,4</sup>—and each holds various degrees of merit and validity. But even if these were remedied and erased, I believe the problem of inadequate pain management would persist.

If pain could be captured like a lightning bug in a glass jar, treatment wouldn’t be a problem. It gets complicated when it becomes invisible and embedded in people who possess a wide and bewildering capacity to tolerate pain, and infinite cunning to use pain, or the ruse of pain, for illicit reasons. Does the patient come to the emergency department (ED) needing my compassion and expertise, or my prescription pad and DEA number for opioids? Investigating and contemplating the patient’s motivation might take more energy than assessing the underlying medical problem or the nature of the pain itself.

With many drugs at my disposal in the ED, I can easily eliminate pain. Holding such a humane and morally cherished goal at my fingertips should fill me with warmth and fulfillment. And yet, it can also be frustrating, exhausting, and strangely unrewarding. No other medical decision burns through the white coat, exposing emotions and feelings so intense that reason, clinical acumen, and best intentions inexplicably and sometimes shamefully get washed away. Inadequate pain management has moral and psychological consequences, especially in the ED, where patients expect immediate help for their problems. Oligoanalgesia is a grave iatrogenic harm; so is inappropriately treating patients with narcotics. My response to a patient’s pain is a litmus test that illuminates what I feel about the patient. Bedrock precepts of the medical profession such as, “First off, do no harm” and “The patient always comes first” are too abstract to fit these moments. Strangely, regardless of what I do, I sometimes feel like a hero, other times like a villain, and most of the time I just can’t tell.

*A middle-aged man presents to the ED with a severe toothache. He has a mouthful of rotten teeth. He doesn’t have insurance, no dentist will see him. He can’t eat or sleep because of the pain. I treat him with Vicodin and he leaves with a prescription for a small number of the same pain medications. A nurse returning from the hospital cafeteria reports that she spied him eating and drinking, laughing. She teases me for being duped so easily. I wonder the same thing, but consider the possibility that with his pain controlled, he could finally eat.*

David Morris in his wonderful book, *The Culture of Pain* (University of California 1991), argues that modern medicine misrepresents pain as purely a medical problem, the creation of anatomy and physiology, and ignores the experience of pain as a phenomenon of the mind, shaped by historical, cultural, and psychosocial factors.<sup>5</sup> Pain is subjective. Only the patient can decide when relief has been achieved. For pain to be treated effectively, however, physicians must give it legitimacy.

Few physicians would argue that relieving pain and suffering aren’t worthy endeavors. Pain can be soul-destroying and isolating. It affects relationships, job performance, and the ability to think and reflect clearly. Pain hijacks patients from who they once were, taking their identity, autonomy, and capacity to control their present and future. Paradoxically, treating pain may cause physicians to feel the same way.

The chaotic and overcrowded ED can intensify the dislocation felt by the patient in pain as well as the physician entrusted to treat it. Emergency physicians are in crisis, too. We care for strangers under tense circumstances. Introductions can be quick and cursory. There is much at stake when two strangers meet in crisis. Each is in a heightened state, and they can intersect in unpredictable ways.

Anonymity can be a source of anxiety for vulnerable patients who know nothing of the treating physician and must trust she will act to the highest moral and clinical standards. Anonymity can equally frustrate physicians pressed to make quick decisions on critical matters with limited information. But anonymity also provides freedom from accountability for both patient and physician. Unmoored from previous relationships, with long odds of future meetings, morally suspect acts may pass without notice and without consequences.



Unspoken character judgments can derail communication between physicians and patients. Patients may become offended when questions take on the tone of an interrogation. They may concentrate more on defending themselves than giving a thorough accounting of their pain. Patients with legitimate pain get their pride bruised and may be seen as difficult. I know a forty-year-old woman who suffers severe migraines and needs to go to the ED for IV narcotics when her migraine-specific medications fail. Once there, she is reluctant to ask for too much medication, even if the pain isn’t entirely relieved, for fear of being thought a drug seeker, and she returns home in pain.

Listening to a pain history requires physicians and nurses to be open-minded and interested. Biases and preformed judgments might prevent what is said from being heard. Insensitive or inadequate attention to pain can devalue the patient’s experience, pushing the already isolated patient further into the dark shadows.

*A middle-aged woman with a history of fibromyalgia and psychiatric problems presents in the ED with severe hip and back pain. She’s tearful and distressed. She hates the looks the doctors and nurses give her in the clinic—they don’t understand. I sympathize, and give her a narcotic and a prescription for 10 pills. Later, I receive a call from the local pharmacy questioning the prescription. Did I really write for 100 pills?*

While oligoanalgesia is considered a public health problem of massive scale, the abuse patterns of prescription narcotics are also escalating.<sup>6</sup> Drug diversion is a serious concern—an estimated 15% of all prescription drugs dispensed in the United States are sold on the street.<sup>7</sup> Such activity is further complicated by the high profile Oxycontin “epidemic” and the illicit and unregulated marketing of prescription drugs over the Internet.<sup>8,9</sup>

Data from large studies show that the appropriate use of narcotics in patients without histories of abuse rarely results in addiction,<sup>10</sup> but regulatory bodies have prosecuted physicians for prescribing what they considered excessive amounts of narcotics to patients in severe pain.<sup>11</sup> This practice drew attention to the prejudices, false beliefs, and poor knowledge of the “experts” sitting on the regulatory boards, and state legislatures and medical boards<sup>12</sup> responded by adopting model guidelines to protect physicians when appropriately prescribing large quantities of narcotics.<sup>13</sup> But one physician, William Hurwitz, was sentenced to 25 years and sent to prison on drug trafficking and other charges.<sup>14</sup> His conviction was overturned because the original jury had been directed to ignore whether Dr. Hurwitz acted in “good faith.” Was he a physician who crossed the line into trafficking or a caring physician duped by a few patients? At his retrial, he was convicted of 16 counts of drug trafficking and was sentenced to 57 months in prison.

Addiction is a disease and relapse is part of the disease, not a character flaw for ED staff to question. Being an addict doesn’t mean you can’t be in pain, and red flags for addictive behavior or illicit motives are often obvious only in retrospect. But when prosecutors join third-party payers in the doctor-patient relationship, physicians have yet another set of eyes looking over our shoulders, and a reason to take the words “Do no harm” as a warning to protect ourselves.

To what extent should our knowledge and fear of addiction and drug diversion affect responsible and compassionate prescribing practices for patients in need?<sup>15</sup> The behavior of street addicts can’t be used to predict the risks of narcotics for patients in pain. The desire or need to escape life drives the street addict to use drugs, while the patient in pain uses medication to engage in life, to regain a functioning place in the family, the workplace, the community.<sup>16</sup>

Relieving pain and alleviating suffering promote the welfare of patients, foster their autonomy, and forge trust in the medical profession. Constipation, nausea, and vomiting are more common consequences of narcotic prescribing than addiction and risk of drug diversion.<sup>17</sup> Inadequate treatment can result in pseudoaddiction: increasing requests for higher dosages or a change to a stronger

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medication, behavior perceived as manipulative and evidence of addiction.<sup>18</sup> What is the greater harm, feeding the occasional drug seeker in the ED or allowing a patient to leave still in distress? Should a small subset of patients with illicit motives deter an overall aggressive approach to pain in the ED?

Framing my uncertainty with this reasoning dances around some raw, less justifiable feelings that can make such encounters a disaster. When skepticism gets the better of me, it defies reason. It's not about the dangers of addiction or the value of beneficence. It's about power. Who has it? If the patient truly comes first, why am I uncomfortable with letting him or her call the shots? If a patient with a urinary tract infection told me which antibiotic worked well in the past, I'd be thankful, not skeptical. In this scenario, with objective, impersonal data to guide treatment, the patient and physician unite

against the offending bacteria. Everybody wins, except the bacteria. But with pain, it feels like one of us wins, or both of us lose. Ultimately, this means nobody wins, except the pain.

Unlikable, suspect patients who seem like "bad guys" have the potential to trick me into being the villain. My probing questions about pain and past treatments are scrutinized and blamed. I might have the

power to treat their pain, but they have the cunning to make me feel like the bad guy. I might react with silence or curt language and still accede to their requests, but my stomach is in knots. I react to their villainy instead of their pain; soon I am the villain.

Social dynamics between physicians and nurses affect the treatment of pain as well. For example, the nurse believes the man with the toothache is seeking drugs. The physician can't be sure and feels uncomfortable not treating him. It will be worse if he has

"real" pain that goes ignored. The nurse openly disagrees. If this pattern continues, a physician in my position can earn a reputation for being soft, or a sucker, and in the process, lose the staff's respect. The opposite situation can be more damning

if nurses feel the physician is "cheap" with pain medication. These potentially contentious situations may disrupt and erode the interdisciplinary trust vital to the doctor-nurse relationship. I have to balance the consequences of a one-time encounter with a patient I might never see again against the opinions of colleagues I work with on a regular basis.

*A young Hispanic male with history of multiple shoulder dislocations presents with a possible shoulder dislocation. He's in severe pain, but doesn't appear uncomfortable. The shoulder x-ray is normal, no dislocation or fracture. My colleague offers ibuprofen or naprosyn. The patient says they don't work well and asks for a narcotic medication that has given him relief in the past. My colleague refuses, and the patient accuses her of racism.*

Stereotypes influence perception. In the ED, where patients become "known" in snapshots of time, preconceived biases and peculiar feelings about patients don't always have a fair opportunity to be proven wrong. For example, blacks and Hispanics are more likely than whites to receive no analgesia for extremity fractures in the emergency department.<sup>19, 20</sup>

Pain's subjectivity forces health care providers to work through uncertainty. Objectifying pain with pain scales has always felt disingenuous to me.

Is the patient who rates her scale at 5 in less pain than the one who places his pain at 8? More concerning, does the number diminish the experience of pain by removing meaning and suffering from the equation and replacing it with a 5? In the end, the 5 removes subjectivity and replaces it with false certainty. Like medicine as a whole, the practice of emergency medicine is a human enterprise. If we ignore the import of emotions, values, and personal history in our relationships, we do so at our peril.

Yet in instances of uncertainty, people unknowingly reach conclusions or make decisions based on heuristic strategies.<sup>21</sup> EDs are always open, and we encounter patients who are obviously seeking drugs for illicit reasons. Unfortunately, patients in honest pain are judged by how they match up against this small, industrious, notorious group. These feel like no-win situations for me and my colleagues in the ED. Believe the patient's pain story and risk the shame of being duped by an addict, and perhaps also the wrath of that addict's doctors and family who are trying to curtail a patient's drug-seeking behavior (who usually are unavailable when the patient presents to the ED!). Provide substandard treatment and risk the shame of failing the patient who goes home in pain. By discounting the pain story I've essentially discounted the patient.

Both doctors and patients can be selfish and distrusting creatures. Physicians need to confess that sometimes reason is usurped by emotion because "our emotions constitute reflexive personal signals."<sup>22</sup> Strong feelings can identify areas where reasoning has as yet resisted articulation, places that need further digging and honest reflection before the public health problem of oligoanalgesia can be solved.

Treating pain is difficult because it drives the professional to transgress the personal in unique ways. It pits doctors and patients, who should be united in common cause, into a power struggle. Subjectivity opens the way to doubt and suspicious speculation. Rare is the clinical situation where the drama is so complicated and nuanced and where, as the drama concludes, the players themselves may be left confused as to who was the hero and who was the villain.

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<sup>1</sup> This focus group participant with sickle cell disease is quoted in Bonham VL: Race, ethnicity, and pain treatment: striving to understand the causes and solutions to the disparities in pain treatment. J Law Med Ethics 29;2001:52-68.

All other italicized examples are composite cases drawn from the experiences of myself and my colleagues.

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<sup>7</sup> Goldman B. How to thwart a drug seeker. Emerg Med 1991;30:49-61.

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<sup>11</sup> Furrow BR. Pain management and provider liability. J Law Med Ethics 2001;29:28-51.

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<sup>16</sup> Vallerand AH. Street addicts and patients with pain: similarities and differences. Clinical Nurse Specialist 1994;8:11-14.

<sup>17</sup> Jacox A, Carr DB, Payne R. New clinical-practice guidelines for the management of pain in patients with cancer. N Engl J Med. 1994;330:651-655.

<sup>18</sup> Weissman DE, Haddox JD. Opioid pseudoaddiction—an iatrogenic syndrome. Pain 1989;36:363-366.

<sup>19</sup> Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. JAMA 1993;269:1537-1539.

<sup>20</sup> Todd KH, Deaton C, D'Adamo AP. Ethnicity and analgesia practice. Ann Emerg Med 35;2000:11-16.

<sup>21</sup> Tversky A, Kahneman D. Judgment under uncertainty: heuristics and biases. Science 1974;185:1124-1131.

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# The Hero-Villain Typology: A Qualified Defense

Daniel Goldberg, JD

The critique of the hero-villain typology is obvious: it's almost Manichean in its dichotomy, it oversimplifies the subtleties of character, and the boundaries between the hero and the villain often seem vague. Given all that, why is the typology so culturally pervasive? From Greek mythology to *Beowulf* to the German Romantic tradition of *bildungsroman* that embodies the narrative of the heroic quest, the hero-villain framing is prevalent in Western literature. Jung concluded that the heroic archetype is 'universal,' appearing in different costumes throughout human history.<sup>1</sup> The fact that the hero-villain typology is deeply rooted in Western traditions does not thereby prove its worth, but there is merit in Edmund Burke's caution that traditions may represent accretions of wisdom that should not be disposed of without good cause. Before consigning the typology to the conceptual wastebasket, it is worth stopping to consider why it has had such extensive and enduring appeal in so much of Western history.

The hero-villain typology is a powerful meaning-making image, and its use in scientific discourse is proportionate with its power. A particularly timely and intriguing example of the influence of the archetype appears in David Oshinsky's book, *Polio: An American Story* (Oxford 2006). Jonas Salk is often regarded as a hero for championing the nexus between science, medicine, and public health. Vaccines, and immunology based on

the germ theory in general, have long captivated public discourse, and as Evelyn Fox Keller reminds us, discourse about science shapes and informs the practice of science itself.<sup>2</sup> The resultant dialectic is, in part, a construct through which participants create meaning about science and its role in their individual lives and experiences. Yet one of *Polio's* most fascinating narratives pertains to conduct of Jonas Salk that seems to raise ethical questions. Oshinsky details Salk's use of institutionalized children in one of his protocols, one group of which had no apparent immunity to polio (which placed them "in a high-risk category"). Salk also clashed with his research staff, which accused him of taking individual credit for work that involved significant contributions from others. The common lionization of Salk as a hero of Western science is eschewed in Oshinsky's book. As is often the case when thinking about history, the cultural narratives reflected in and about particular discoveries are more complicated than a simple hero-villain framing suggests.<sup>3</sup>

The hero-villain typology resonates in literature about scientific practice as well. Thirty years before Salk produced the polio vaccine, the fictional character of Dr. Martin Arrowsmith grappled with commitments to science, clinical medicine, industry, and family in Sinclair Lewis's 1926 novel. The opening page of *Arrowsmith* sets out a quintessentially

heroic trope: at the age of fourteen, Arrowsmith's great-grandmother literally takes up the wagon reins to go West. Though the girl's mother had died, her father was ill, and numerous younger children played about the wagon, she sets forth toward the sun, exclaiming, "They's a whole lot of new things I aim to be seeing!"<sup>4</sup>

*Arrowsmith* is a canonical work in the medical humanities. Dr. Arrowsmith is at once hero and martyr to the cause of science, at times acting in arguably villainous ways toward his family—virtually abandoning his first wife Leora, who then dies of plague utterly alone and terrified, and abandoning his second wife and young child to pursue scientific inquiry unencumbered by filial attachments. Arrowsmith's character plays on the hero-villain archetype, as do the narratives of Salk explored in Oshinsky's work, stretching and testing it within the context of one man struggling with commitments to science, clinical practice, public health, and family.

The hero-villain typology is pervasive in Western discourse about science and medicine because it is a powerful representation and because the archetype facilitates the construction of meaning. As Nietzsche explained in *On the Genealogy of Morals*, the significance of meaning in the face of suffering cannot be underestimated. Indeed, the very scope of the typology's narrative power recommends great caution in its usage. Like any powerful social narrative, it can create great mischief as well as

augment human flourishing. This is why I offer only a qualified defense of it. But, as Oshinsky and Lewis both show, the complexity of the interplay between the heroic and the villainous is part of what continues to shape our public discourse about science, medicine, and public health. Its very capacity for meaning-making suggests that its abandonment could undermine our own

narrative quests. The hero-villain typology can be a source of strength for ill people and caregivers looking for meaning in the face of suffering, and that strength would be lost if we abandoned it entirely.

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<sup>1</sup> Nigel Kaw, "The Comicbook Superhero: Myth for our Times," 8 *Refractory: Journal of Entertainment Media* (2005), <http://www.refractory.unimelb.edu.au/journalissues/vol8/kaw.html>.

<sup>2</sup> Evelyn Fox Keller, *Refiguring Life* (New York: Columbia University Press, 1995).

<sup>3</sup> Mirko Grmek, "A Plea for Freeing the History of Scientific Discoveries from Myth," in *On Scientific Discovery: The Erice Lectures 1977*, Mirko Grmek, R.S. Cohen, Guido Cimino, eds. (New York: Springer Press, 2006).

<sup>4</sup> Sinclair Lewis, *Arrowsmith* (New York: Modern Signet Classic, 1998): 1.

# Can Doctors Take Back the Script?

## Understanding the Total System of Prescription Generation

Michael Oldani, MS, PhD

Pharmaceutical industry math is quite simple: profit is realized by convincing licensed prescription writers to write prescriptions, or "scripts," for a company's products. Billions of dollars are spent on influencing the simple act of writing a few words, of putting pen—preferably one that says something like "Ambien"—to a tiny sheet of paper. This act, encompassing a few seconds, sets both curative and profitable paths in motion and is the foundation for arguably the most lucrative industry in the world today.

The industry has successfully infiltrated and influenced all aspects of the script-writing process with tactics like drug rep detailing, "expert" speaker/CME programs, PR companies, ghost writing of clinical trials, gifts of every level (from pens to paid vacations), and direct-to-consumer (DTC) advertising. Today, no aspect of the script-writing process remains pharmaceutically neutral. In sociological parlance, the industry has worked very hard to create and maintain a "total system" of prescription generation.

For the industry, the symbolism of the gift of a cheap plastic pen is profound: the power and profit of the script lies within it.

## Big Pharma as Hero/Villain

I understand the power of the pen because of my somewhat unusual career path to medical anthropology and the growing field of "critical pharmaceutical studies" (CPS) (Oldani 2004). In the 1990s I was a drug rep for Pfizer Inc.—the most aggressive marketer of prescription drugs at the time (Kirkpatrick 2000). This was the "blockbuster" era, the period that saw the creation and marketing of drugs that gross at least a billion dollars in annual sales. (Viagra and Celebrex were the first true

blockbusters [\$1 billion in year one on the market]. Lipitor is currently the ultimate blockbuster, approaching \$15 billion in annual sales globally.)

In many ways the drug rep, or "detail man," embodies both the heroic and villainous qualities of the industry. It was not uncommon for doctors to thank me for detailing them on Diflucan (fluconazole) because it saved a patient's life in the ICU, but saving lives was not enough. On a day-to-day basis drug reps also have to "make quota" on a drug like Diflucan, which can lead to all kinds of unscrupulous and unethical practices, such as selling "off label," promoting higher doses, high volume gifting, and *quid pro quo* activities.

In the U.S. medical marketplace, the pharmaceutical industry operates within an ethical paradox—creating potentially life-saving or life-altering drugs, and also needing to satisfy the demands of Wall Street. The majority of drug reps would see promoting their life-saving drugs *and* exceeding sales quotas as heroic, and some patients and families who benefit might agree with the former. Yet many bioethicists deem much of what the industry currently does to garner profits villainous. Big Pharma actually thrives within this binary of the hero-villain. It spins this black-and-white dichotomy to its benefit, and it grays the boundaries of the dichotomy to meet its needs.

For instance, the industry rebuts the framing of drug reps as villains who should be banned from teaching institutions and medical clinics with one of its most persuasive myths: the industry performs a service to the medical community. How else will "busy" doctors find the time to learn "new" clinical information about potentially life-saving

drugs? At a more macro-level, the industry will spin any negative portrayal of the industry itself into the \$800 million dollar question: "Who" else will (read: will "government") invest that kind of money into the development of "one" new pharmaceutical product? This is another powerful myth that Washington lobbyists have made into an everyday medical-pharmaceutical truth, despite research showing that the majority of the \$800 million is spent on the *post-marketing* development of "me-too" compounds in order to find new indications and markets (Goozner 2002). "New markets versus new medications" is just one of the many apparent contradictions the industry is able to use and spin to its advantage. Spinning is ubiquitous at every level of industry promotion. During my time as a rep, we welcomed objections from doctors, because seizing these moments gave us more time to spin negatives (i.e., product side effects) into positives (i.e., efficacy and cost-effectiveness) (Oldani 2004).

In addition to conceptual spin, the industry works hard to blur the "good guy-bad guy" dichotomy in concrete ways, to the point where ethical contradictions are part of the "system," part of the costs of the medical-industrial complex. There are constant migrations of scientists and doctors between the public and private research sectors (Rabinow 1996); both state and federal governments are constantly promoting research alliances between Big Pharma/biotech and public institutions such as universities and medical schools, and it is quite common to find medical school deans on the corporate boards of pharmaceutical corporations and vice versa. (This also happens to pay very well.)

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So when these same medical schools begin to vote on whether or not to “ban drug reps” from the building, other systemic factors come into play and phrases such as “it’s complicated,” “not quite sure what to do,” “this is part of the business model today,” “reps have a job to do,” and “banning pizzas won’t do any good” become the norm. This “muddying of the waters” makes the black and white binary of heroes and villains very gray and allows the total system of prescription generation to continue unabated by ethical concerns (Oldani 2002, 2004).



## Taking Back Scripts, Step by Step

The good news is that regardless of the vast amount of information, gifts, and money being exchanged to influence doctor prescribing habits at every level of the medical-industrial complex, doctors still hold the power in their hands, within their plastic pens, to make changes if they choose to do so.

One strategy some doctors use is to become a “no see” physician. (See [www.nofreelunch.com](http://www.nofreelunch.com) as a medical-social movement in this direction.) However, as a “solution” this is naïve if one does not understand the nature of this total system of prescription generation. For example, a “no see” will still write prescriptions for an antibiotic listed on her hospital’s protocol, and that protocol may have been written by a drug rep, a tradeoff made to alleviate the stress and workload of the clinical pharmacists at her teaching institution (Oldani 2006).

A more productive strategy would be increasing the transparency of these

processes. Unfortunately, that “transparency in prescribing” has worked like a one-way mirror in favor of the pharmaceutical industry so far. Understanding what’s happening on the other side of that mirror is the first step toward a different kind of transparency, one that would (at minimum) flow both ways, in order to help physicians and their patients.

Drug reps have been able to see on paper what prescriptions physicians are writing since the mid-1990s. The increased use of script-tracking technology coincided with the blockbuster era, an era that also saw the advent of

prescribing data with the AMA master file of doctors, which is then sold to the industry by third parties (AMA, n.d.). Recently, the AMA has created an “opt out” program that allows doctors to have their names removed from script-tracking lists (see [www.ama-assn.org/go/prescribing](http://www.ama-assn.org/go/prescribing)). However, even if physicians opt out, this information still makes its way to marketers and managers at the corporate level, and we’re relying on the industry to police its own activities (Whitney 2006).

If doctors do not opt out, drug reps and sales managers receive data that reads like this: Dr. Smith—June 2002: Prozac 34 (prescriptions), Zoloft 17, Paxil, 29, Celexa 10, Effexor 8 (etc.) for every doctor in a rep’s territory! A representative who sells an SSRI has all the information needed to target specific doctors, often referred to as “high prescribers.” Prior to information like this, drug reps took months or years to compile their own script tracking by talking to doctors (who often lied to avoid confrontation), nurses, and pharmacists as well as observing drug sample movement at clinics.

Today, script tracking puts this information at the fingertips of 12,000 plus drug reps in the United States for every class of prescription drug. Beginning in the 1990s high prescribers were targeted like never before, often being “co-marketed” by reps within the same company. The synergy between script-tracking technology and sales and marketing practices during this era significantly impacted prescribing habits, and fueled the growth of blockbuster markets (Elliott 2006 and Oldani 2002, 2004; see also Greene 2007a for a history of prescription surveillance beginning in the 1940s.)

## Transparent Scripts

Big Pharma has been able to clearly see what physicians write for almost a decade. More recently, concerned clinicians, bioethicists, CPS scholars, journalists, and legislators have begun pulling the curtain back on Big Pharma and allowing physicians a reciprocal view.

One version of reciprocity aims to reduce the transparency of the medical profession. New Hampshire is currently the only state to ban altogether the use of script-tracking technology by the pharmaceutical industry, but Maryland is working on similar legislation, and these developments could lead to change at the federal level.

Another version of reciprocity aims to increase the transparency of pharmaceutical industry financial exchanges with doctors. Vermont and Minnesota now require physicians to report on the money, stipends, and grants they receive from the pharmaceutical industry (Ross, et al. 2007). *JAMA* published the first study of its kind to look at the data generated by Vermont and Minnesota, and although the authors are disappointed in shortcomings of the logistics of the states’ reporting systems, the practice of disclosure is an important first step in creating more of the kind of transparency that benefits patients in the script-writing process.

Academic writing has also increased the transparency of the total script-writing system since the late 1990s. Assessing the impact of gift exchanges on prescription writing (Wazanna 2000, Oldani 2004), exposing the ghost writing of clinical trials (Healy 2004), and the use of PR companies to create medical educational programs (Elliott 2004) are all examples of dissecting the prescription-writing process. The May 31, 2003 issue of the *British Medical Journal* is a seminal volume dedicated to understanding the total system of pharmaceutical sales practices. In this issue almost every aspect of pharmaceutical industry influence is mapped out and critiqued, from gift exchanges to clinical trials. More recently, two books have described the ways the pharmaceutical industry, through the research, development, and

marketing of new drugs, has impacted (and created) new diagnoses and medical disorders. These investigators show that the (over)prescribing of drugs, such as the SSRIs and statins, has led to diagnosing more mental health disorders and lipid-related disorders and changed the way doctors and patients perceive these disorders (Moynihan and Cassels 2005, Green 2007b). Pharmaceuticals, especially psychotropic medication, can become part of a self-perpetuating prescription loop, where drugs are used as “diagnostic tests,” prescribed empirically before a diagnosis is made, yet pointing clinicians towards a specific diagnosis if symptoms are relieved (Oldani 2006).

If doctors wish to take back the script all these developments are positive, but transparency isn’t synonymous with change. Are these collective efforts leading toward fundamental changes in the way the pharmaceutical industry conducts its day-to-day business? Is the total system of prescription generation on the cusp of major change?

My answer is a tentative “yes.” Over the last several years my talks with residents and medical students have given me the sense that there is a growing “uncertainty” among doctors-in-training regarding relationships with the industry, and I think that’s partly attributable to the descriptive efforts and increased transparency of Big Pharma described above. Another part of their uncertainty is related to concerns with patient safety

and side effects of over-prescribed blockbuster drugs like Vioxx and Paxil. These future script writers are thirsty for “objective” pharmaceutical information (e.g., The Medical Letter and the Drug Therapeutics Initiative at the University of British Columbia) and they’ve made it part of their medical training to know how Big Pharma attempts to affect the prescription-writing process. Some of these new doctors will become “no see” physicians, but the majority seem resistant to the villain-hero binary. Most of the students and residents I talk with would rather understand the “system” from a critical perspective in order to have more certainty about the prescriptions they will be writing on a daily basis.

Lastly, the industry itself may be caught in its own double bind. The collective push for more transparency has driven some companies towards full disclosure, in particular within the area of clinical trials. GlaxoSmithKline, which withheld clinical information in the past regarding side effects related to Paxil, agreed (as part of a legal settlement with the state of New York) to post online all the clinical trials (published and unpublished) related to its top-selling drug for diabetes treatment, Avandia. Clinicians quickly analyzed the data and concluded in published reports that patients being prescribed Avandia were at increased cardiac risk (see Meier 2007 for complete discussion). It’s not entirely clear where this type of transparency will lead doctors, lawmakers, and patients in the future, but it appears to be a step towards increased scrutiny by doctors and the public concerning the inner workings of Big Pharma.

## The New Script Writers: The Patient/Consumer

The final piece of the prescription-generating puzzle that needs to be fully interrogated by bioethicists and CPS scholars is precisely where uncertainty remains for medical students and residents: how should physicians deal with increased consumer demands for pharmaceutical prescriptions? Patients are key players often overlooked in the Big Pharma hero-villain binary, but in the current state of pharmaceutical culture, a new binary is emerging—demanding and potentially misguided patients wanting their brand name drugs, and heroic doctors attempting to hold on to their script pads.

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# A CONVERSATION WITH DR. TIMOTHY QUILL



WHEN HIGH-STAKES MEDICAL ETHICS CONTROVERSIES ENTER PUBLIC DISCOURSE AS NEWS STORIES, PRIVATE PHYSICIANS MAY FIND THEMSELVES CAST AS HEROES OR VILLAINS. AS ONE OF THE MOST PROMINENT FIGURES IN THE POLARIZING DEBATE OVER PHYSICIAN-ASSISTED DEATH, DR. TIMOTHY QUILL HAS BEEN PAINTED AS BOTH. HE SPOKE TO ATRIUM ABOUT HIS EXPERIENCES WITH MEDIA, COURTS, PATIENTS, AND ACADEMIC MEDICINE.

**Katie Watson:** In 1991 you disclosed that you helped your patient Diane end her life in your now famous article, “Death and Dignity: A Case of Individualized Decision Making.” Why did you choose to make your actions public at that point? What consequences did you think would flow from that choice, and what actually happened?

**Timothy Quill:** I had long been an advocate for increased patient choice at the end of life. Although I had indirectly assisted many patients to die in my career as a general internist and hospice physician, my decision to assist Diane unfolded in a way I had not previously encountered.

Exploring Diane’s dilemma, two elements emerged that remain central to my thinking and clinical practice today. First, some patients need to know that they will be able to control their dying as much as possible, and that if their suffering becomes intolerable, they will be listened to, taken seriously, and responded to creatively.

Second, if we as clinicians make this commitment, we must be prepared to be as responsive as possible if suffering becomes unacceptable to the patient and cannot be relieved with available palliative treatments. Diane wanted to live as long as possible, and she took many life-prolonging therapies during her three months on hospice. She only took her life with the medicine I had provided when her time would have been measured in hours to days—time that from her point of view would have been worse than death because of the more severe physical symptoms she was experiencing.

I had talked to several respected and experienced colleagues both during Diane’s illness and after her death, and learned that many had similar experiences—they had assisted a patient or two in secret, with no second opinions to assure they had fully considered all alternatives, and no support after the experience. When we help patients die by stopping

a life support, their medical records document exactly how the decision was made, what alternatives were considered, what second opinions were sought, and what was done to alleviate the associated suffering. But more direct physician-assisted dying, by knowingly providing patients with a potentially lethal prescription, remains underground and undetected because of its uncertain legal and ethical status. I use the more descriptive term physician-assisted death (PAD) rather than the more inflammatory term physician-assisted suicide (PAS) to describe this practice. Although “suicide” may be technically and philosophically correct, the term connotes a self-destructiveness that is generalized from mental illness, and that’s simply inaccurate and misleading for these patients. They have no desire to die, but rather see their lives and personhood being destroyed by their illness, and they therefore come to view death as a form of self-preservation—the polar opposite of the meaning of suicide. The state of Oregon has recently changed its language around this practice, as has the American Academy of Hospice and Palliative Medicine.

About this time, public discourse about PAD was dominated by provocative and challenging behavior from Jack Kevorkian. Diane Meier and Christine Cassel wrote an article in the *New England Journal of Medicine* entitled “Beyond Morals and Moralism in the

Debate about Physician-Assisted Suicide,” in which they argued that the fact Kevorkian was easy to morally dismiss didn’t mean the issue raised by these patients should be so easily dismissed. They and others expressed a desire for some real cases that would allow a deeper exploration of the underlying issues.

I was a respected academic general internist with a lot of hospice experience, so I was not as easy to dismiss as Dr. Kevorkian. I hoped writing about Diane’s compelling story would challenge medical thinking and deepen the public discussion beyond “all people need is better palliative care and this issue will disappear.” When I sent the narrative to *NEJM* I got a surprisingly quick response from then-editor Marcia Angell. She said she thought the article was important, and asked whether I was sure if I knew what I was getting into.

I grossly underestimated the level of interest at all levels. My patients were very supportive, and I received thousands of letters. The vast majority expressed gratitude and related personal stories kept secret for many years, which let me know that the article touched on something profound in the lives of these people and their families. I had clearly tapped a chord that was much deeper than I was aware at the time. Many of these patients and their families saw me as a “hero” for standing up for Diane, and indirectly for them. There is clearly a large group of patients, probably a majority of the population, who would like to have this possibility at the end of their lives even if they choose not to exercise it.

There are also a substantial number of people who are adamantly opposed to PAD. Some understand exceptional cases like Diane’s, but legitimately worry about the unintended potential consequences of a public policy which would legalize this response to such cases. A small number of these people saw me as a “villain,” saying that I was even

more dangerous than Dr. Kevorkian because I presented this immoral issue under the guise of medical legitimacy and compassion when it should have absolutely no part of medical practice. Some second-guessed every aspect of my management of Diane’s case and of my character. A few demonized me in direct terms, and a few simply threatened me in this life or the next.

I also underestimated how much interest there would be from the press. I was immediately inundated by requests for interviews from all major national television networks and many newspapers and magazines. In general, I was treated very sympathetically in this first wave, but at the same time I was being interviewed, the same reporters were pressuring the local prosecutor, the university, and my professional societies about how they were going to respond to my “case.” There was much speculation about whether I made up the case, and if not, why didn’t I come in and talk to the prosecutor about the details?

My university began to distance itself from me. The administration put together a review panel, pre-selecting the members in a way that guaranteed a unanimous conclusion that this was my personal view and not that of the university. (Ironically, my status changed dramatically after a new administration came into power, because this one was sympathetic to the issue and liked faculty members at the cutting edge of current issues.)

I quickly realized I was in over my head, and I retained a criminal lawyer. My new lawyer immediately gave me advice to stop talking publicly about the case and see how things played out. Before I published the article about Diane I got legal advice from some well-known legal scholars who told me there was “no way I would be successfully prosecuted” for writing this narrative. Although this ultimately proved true, what I subsequently learned is that you can go through a significant legal process on your way to not being successfully prosecuted.

To make a long story short, after several months, an “anonymous tip” told the prosecutor who Diane was (despite the fact that many people in our community knew full well who she was). She had donated her body to science at one of our local universities, and her body was seized by the local medical examiner. An autopsy confirmed the high levels of barbiturates in her system, and the prosecutor sent the case to a grand jury. I waived my 5th Amendment rights and testified on my own behalf (as did several well-known local colleagues), and the grand jury chose not to prosecute.

Two other venues played out in parallel. First, a New York State professional ethics panel was asked to evaluate my professional conduct. It was a real roll of the dice to have this three-person panel have a major say about my professional future. They concluded that I had acted professionally and referred the issue to the New York Task Force on Life and the Law for subsequent review. I was very lucky these three clinicians were sympathetic to the dilemma, and I am thankful for their thoughtful deliberations.

When I felt professionally or personally threatened in the process, I harkened back to the threats and challenges faced by patients like Diane, and it made my worries seem relatively small. On the other hand, unlike Dr. Kevorkian, I had no desire to be a martyr, and I was truly relieved when my legal problems went away.

**KW:** Like physicians who forget to fully explain the pain that can follow worthwhile surgery, I think we lawyers can forget how painful litigation can be, even when it’s a “success”—sorry! Given your experience with the law after

the Diane article, why did you agree to become a named party in *Vacco v. Quill*? What was your experience as that litigation made its way to the Supreme Court in 1997?

**TQ:** Yes, the surgery was a success and the painful parts were soon forgotten—though if I had gone through a full trial and accompanying media circus, or if I had lost my license because of the arbitrary action of a different professional review board, I might feel differently.

This time I began by fully exploring the risks and benefits of my participation with both criminal and academic lawyers, and learned that there would be minimal legal risk for me personally. I believed it was useful to challenge the laws that allow some patients to be assisted to die openly (those who happen to be on life supports) whereas others whose suffering might be many times greater were not offered similar legal choices. I also hoped that becoming one of the named plaintiffs would help ensure that mainstream clinicians would consider the law more seriously. The litigation was a very long-drawn-out process, but my professional or personal life did not hang in the balance. I was surprised and honored that the case went all the way to the US Supreme Court, and watching the oral arguments I was in awe about the complexity and history of the process. Although we lost 9-0, I felt encouraged by the seriousness with which the questions were addressed, and by the way the decision allowed the middle ground to move forward in terms of palliative care and end-of-life options for seriously ill patients and their families.

**KW:** Dr. Kevorkian was just released from prison after serving over 8 years of his 10-25 year sentence for second-degree murder. You’ve written an article titled “Dr. Kevorkian: Hero, Villain or Something in Between?” Have you ever sat down and talked with him? How do you think history will view his role in the physician-assisted death debate?

**TQ:** Dr. Kevorkian has certainly been a lightning rod. His role has been quite complex. On the heroic side, many respect and admire his willingness to stand up to the medical and legal establishments for what he believed was right. He laid down a gauntlet which basically said if mainstream doctors are going to ignore your suffering, I will be there to respond. He was willing to go to trial and eventually even to jail for his convictions, and the families of the patients he assisted certainly see him in heroic terms. I also think that he forced the public and the profession to more fully and forthrightly explore the questions associated with how physicians should respond to intractable suffering.

On the other hand, many of the patients Dr. Kevorkian assisted did not have a terminal illness, and some did not even have a defined physical illness at all. As a pathologist, he did not have the clinical training to evaluate such seriously ill patients and to determine if their diagnosis was correct, if they had adequate attempts to palliate their suffering, and if they were mentally capable of making such decisions. The ease with which he was willing to end so many lives was deeply disturbing, as was the fact that he seemed as interested in promoting himself and his crusade as he was in assisting and treating patients. The images of suicide machines and seriously ill patients dying in the back of a Volkswagen van are emblazoned in our collective memory as a challenge to us all. The circus atmosphere surrounding him devalued the profound topic about which he was forcing discussion.

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In my opinion, Dr. Kevorkian will be remembered as a uniquely American phenomenon who pushed the envelope of end-of-life options as far as he could, and forced us as a society to take the questions and issues faced by dying patients and their families more seriously.

I had several opportunities to be interviewed with Dr. Kevorkian on television, and chose not to. I did not want to be directly associated with him, and also really believed that his provocative behavior had the potential to overwhelm any more moderate message I was trying to deliver. His presence in the public debate was useful to get the discussion started, but once there was momentum to improve palliative care and find more last-resort options that could be openly discussed and offered within mainstream medicine, his antics became a distraction.

**KW:** Earlier you said PAD “remains underground and undetected because of its uncertain legal and ethical status.” What’s uncertain about its legal status?

**TQ:** Approximately 14 states don’t have specific laws on the books about PAD, though it’s still probably illegal. The legal status of PAD is clear in Oregon, and approximately 35 states have laws specifically prohibiting this kind of assistance. But there are many reasons prosecutors and medical examiners are not eager to pursue these cases, and these laws can be difficult to enforce, in part because real acts of PAD have a certain amount of ambiguity. There are clear clinical and legal distinctions between PAD and terminal sedation—terminal sedation theoretically requires that one’s intention is entirely and unambiguously to relieve suffering, and not to hasten death. However, to maintain this purity of intent with terminal sedation, a challenge remains as to how to justify stopping life-sustaining therapy at the same time (as is almost always the case). Another challenge is how to justify the practice when it is the patient’s intention in choosing sedation to both escape suffering and to hasten death. Although terminal sedation appears to be legal in view of the 1997 Supreme Court decision, it has never been explicitly tested and it probably has standards of intention that are unrealistic.<sup>1,2,3</sup>

**KW:** A decade has passed since the Supreme Court decided there is no constitutional right to PAD, which left its legal status up to the states. Only one state has legalized it and the flurry of energy behind ballot initiatives and legislation seems to have passed. Are you ready to concede defeat?

**TQ:** I don’t believe the physician-assisted dying issue is “defeated.” Although legislatures nationwide currently have little taste for this (or almost any other) ethically complex area, there will likely be a ballot referendum in the state of Washington in the next election cycle, and early polling looks very promising. Furthermore, the data from Oregon is very reassuring that the practice can be safely regulated, and that it will not undermine and may even promote excellent palliative care. PAD accounts for only 1/1000 deaths in Oregon, but 1/50 talk to their doctors about it and 1/6 discuss the issue with their family. Oregon is among the leaders in the nation in other markers of good palliative care including opioid prescribing rates, deaths at home rather than in medical facilities, hospice referral rates, and educational programs for medical professionals.

It’s also the case that the number of options available to seriously ill patients nationwide has expanded over the past 10 years. First and foremost, the palliative care movement has grown exponentially. Patients no longer have to wait to get

good pain and symptom management until they stop standard medical treatment—the two can be provided side by side throughout a patient’s illness—and when they choose to stop standard medical treatment, first-rate hospice care is widely available. There is also now a clear acknowledgement that there will always be a small number of difficult cases where suffering becomes intolerable despite our best efforts in providing palliation. For such unfortunate patients, an increasing number of “last-resort” possibilities are now legally available, including high doses of opioids to relieve pain or shortness of breath, the ability to stop any and all unwanted life-prolonging treatment even if the patient’s motivation is to hasten death, the possibility of voluntarily stopping eating and drinking, and finally terminal sedation—sedation to unconsciousness to treat intractable suffering, and then withholding of hydration and nutrition and other treatments.<sup>4</sup> Although there remains considerable ethical controversy around several of these practices, and their availability varies throughout the country, they appear to be legally permissible and they give patients and their doctors alternatives to PAD if suffering becomes intractable.

**KW:** You’ve mentioned how others might view you. Do you personally see anything “heroic” or “villainous” about your choices, actions, or speaking and writing with regard to PAD?

**TQ:** I have always believed that we should be as responsive as possible in the care of our patients, especially those who are entering the last phase of their lives. I don’t think there was anything particularly heroic or villainous about my decisions with Diane or the small legal risk I took on her behalf. All of it was driven by a commitment to the particular patients who come under my care.

My decision to write and publish about the experience involved bigger risks because it challenged an accommodation that had been achieved in society to nominally prohibit the practice while tacitly allowing it. I was quite naïve about the legal and political consequences I was getting into, but most of the previous discourse in the medical literature did not do justice to the genuine dilemma faced by patients like Diane who wanted to have this option, and it in fact discounted and even belittled their suffering. I did not and do not see my decision to publish a challenging paper as heroic. It probably more reflected my reaction against authority when it is exercised in ways that seem arbitrary and hurtful to people I care about.

Commitment, empathy, responsiveness, fidelity, and medical skill are the professional qualities required of all medical providers taking care of seriously ill patients. They might be admirable if done well, but they are certainly not heroic, nor are they optional.

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## RESPONSES TO

## “Is there a doctor in Greg House?”

BY KATHY NEELY, MD, *ATRIUM*, FALL 2006

# A Challenge to the Profession: Dr. House

*Ann Starr, MA*

Be wary, good doctors who monitor ethical concerns, when you find yourselves wagging a finger at television’s medical bad boy, Dr. Gregory House.

Dr. Kathy Neely writes with concern that House’s weekly failures of empathetic listening, his neglect of therapeutic relationships, his intimidation of team members, and his wanton crossing of professional boundaries corrode medical education. His spectacular want of sensitivity in dealing with peers and patients militates against good diagnosis, she argues. The television program, in presenting such a character at all, makes patients worry about the medical profession.

Patients *shouldn’t* be worried about the medical profession? While the profession, both inside and outside of TV-land, bites its nails over House’s naked transgressions, are we to take it that the hospital is otherwise an ethically well-regulated system?

I hardly think so. Greg House isn’t the ethical problem on this program. He is the prism that focuses the hospital’s many ethical problems otherwise known as “standard operating procedures,” “budget constraints,” “insurance mandates,” “privacy regulations” and the like. Dr. Neely, like House’s Princeton colleagues, implies that medical ethics is the exclusive purview of the doctor. The doctor’s first big ethical task is to be respectful (read, “nice”) to patients—to everybody.

House refuses to compartmentalize his job in expected ways. He is a renegade. House breaks rules. But is House unethical as a result? Does he fail the best interests of his patients?

House’s job is to save lives. His *personal reasons* for achieving the goal always seem bizarre, solipsistic, or perverted. But his colleagues and patients don’t have to understand his motives since he is entirely consistent in his pursuit of saving lives. He is the ultimate professional, completely tenacious even if inscrutable in other dimensions. Mortally ill patients will get over puzzlement or insult, but not death.

Pursuit of House’s goal has involved multiple breakages of the CT scanner. The scanner is equipment made for diagnosis in the service of saving lives. Objection to his use



of the scanner is based on the hospital budget, which is *not* entirely in the interest of saving patient lives.

Dr. House is entirely surprising in the things he says in patients’ rooms. He’s shocking. Objectionable. But is he a bad listener? Can it even be said he is not an empathetic listener? House’s unusual, often brutal, techniques of provoking big responses get people to reveal facts from the impolite sides of their lives—sexual secrets, unrepented atrocious acts, closeted family histories—secrets consciously or unconsciously hidden. In the Holmesian world of this program, these *will* affect the case, and House *never* fails to hear the details.

Now, attending oncologist James Wilson is as *nice* as can be. House’s foil has excellent communication skills, and he’s capable of those therapeutic relationships Neely calls for. He’s so nice, in fact, that he sleeps with sad patients (suppressing awareness of his *own* neediness) and writes illegal prescriptions for his drug-addicted friend. His niceness, in fact, cripples him. Wilson is incapable of imagining any way to escape nice. When he faces a problem that sympathy and rule-following can’t solve, he invariably elects some form of rationalized compromise or deceit. He is incapable of being simple or honest, stifled as he is by his persona of decency.

Yet critics don’t cry out against Wilson. He is easy to sympathize with, being so nice, but he is at least as

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transgressive as House. He is more so, because Wilson hides his transgressions, just as he hides his miserable personal life. Everyone knows and carries on about House's torment. Wilson, *like so many doctors*—especially substance abusing doctors—is a nice guy who pushes reality entirely underground, where it needn't be examined.

Another foil for House is his fellow, Dr. Cameron. She is so sensitive to ethical dilemmas that she was virtually paralyzed much of the first season. In Cameron, ethical decisions are presented in the familiar guise of ethical poles: Rights and Wrongs, with gray areas as the vast impenetrable swamp where she refuses to go. For House, the swamp is everyday reality.

*If I'm in an opaque and mortal situation, I want an inquisitor. I'll take the insolent one who will pull out the stops, infuriate my loved ones, stretch the patience of his specialist colleagues, and dig through my panties if he thinks it will yield anything to save my life.*

In the first season, Cameron's primary actions were refusals. Her disagreements on ethical decisions would prevent her from participation in cases, her high-mindedness and thin skin moving her to the sidelines. As Neely points out, she resigned at one point and later came back. Was it only for self-punishment as Neely suggests? Or because she saw that doctors have to be engaged? Doctors *practice*.

In the first season, the debate about bioethics was posited through Cameron on the one side—bioethics as a sequence of equally weighted, verbally-defined principles to be upheld through a decision to participate or withdraw—and House on the other, insisting on ethics as pragmatism and action: save the patient, whatever it takes, no points for style. Life is the good outcome.

This season the character of Cameron has changed significantly. No longer the hand-wringing young woman, this year she even accomplished the euthanasia a patient requested. While we find her weeping in the chapel at the episode's end, she is sitting erect with her eyes open. The rulebook has crashed into the swamp. House consoles and congratulates her with genuine kindness.

The last critical player is Dr. Cuddy, the hospital administrator. Cuddy is House's nemesis and his greatest supporter. She has passionately protected his job because he is their most brilliant doctor—and we understand that she likes him. Yet she constantly warns him about lawsuits, the costs to the hospital of his perceived misadventures, the danger of his risky practices, and the foolhardiness of his egomaniacal ways.

Cuddy browbeats House like a naughty child. Some of this is sexual play scripted between these characters. Beyond that, though, the infantilization of House has to be taken

seriously as part of the hospital's ethical world too. House's actions make Cuddy look ineffectual, increase the hospital's liability, potentially decrease its drawing power, and make it harder to raise funds. Cuddy resorts to a maternal course of badgering and rewarding, and negotiates constantly with her darling who is "prone to tantrums."

Cuddy's position isn't enviable, but to treat House as a bad boy is to deflect the fundamental challenge he presents to her and the whole premise of the hospital. Were she to treat him like the rational man he is, she would have to face the big questions about the system of medicine his every action implies: Where do we draw the line when we deny resources to save a patient's life? Why do we draw a line at all? How do we evaluate verbal and philosophical, compared to pragmatic, active bioethics? If all doctors are expected to use the same "ethical" tools—literally to speak in the same nice voice—when does ethics become a mere rulebook? How, then, do you separate the well-meaning but idle-minded practitioner from a more deeply engaged ethical practitioner? Do we want a culture of doctors who hide behind well-rehearsed lines, flinching from deep questioning and questioners—the Wilsons? Are we satisfied with playbook ethics, or shall we literally *practice* ethics, learning and doing what is right from case to case?

If I'm in an opaque and mortal situation, I want an inquisitor. I'll take the insolent one who will pull out the stops, infuriate my loved ones, stretch the patience of his specialist colleagues, and dig through my panties if he thinks it will yield *anything* to save my life.

So in terms of medical education, I say, *Hooray* for House. Don't change that station, students! Because I want medical students to see images of doctors who are not docile. Show them doctors standing up on their own authority, not assuming that they have to be compliant in every detail of the system, maintaining the suave face of The Profession. I'd like to see med students develop their ethical codes from the ground up, from inside, comparing their own terms to the terms proposed in essays and grand rounds. I'd like them to have lots of practice reflecting deeply, speaking and fighting for their ethics in particular cases, à la House.

Most of all, I'd like upcoming doctors to assume that their patients are not so simple that they equate dulcet voices with good doctoring. Sometimes real patients—unlike those in TV-land—understand that excellent practitioners aren't always golden-tongued or speak great body language.

Patients do tend to recognize, however, that medical respect lodges in nothing so much as a doctor's trying really hard to keep the sick from dying. *Really, really hard*. Like House does.

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## Is "House M.D." a Danger to the Children?

*John Lantos, MD*

The hero of the prime time drama, *House M.D.*, is modeled on Sherlock Holmes. House's name is an allusive pun ("house" = "holme"), and his apartment has the same number as Holmes' famous Baker Street abode—221B. He loves to make diagnoses based upon careful observations of the patients he is treating, just as Holmes was famous for drawing conclusions about people based upon his exquisite attentiveness to details—their clothes, their accents, the mud on their shoes, or the calluses on their hands. Holmes plays the violin, House the guitar. And they're both addicts. Like Holmes, the irascible Dr. House likes nothing better than slaughtering sacred cows.

The arc of each episode is formulaic. The disease is never what it initially appears to be. Clues are all around but they are missed. Often, the patient's suffering comes not from the disease but from the medical interventions. House is a brilliant diagnostician, yet in each episode he comes up with 2 or 3 wrong diagnoses before he hits upon the right one. Often, his mistakes nearly kill the patient before he finally makes the correct diagnosis. Usually, the patient recovers. The clear message is that life is tenuous and disease lurks everywhere and could strike at any moment. When it does, we need the best doctors or else we will die. There aren't too many good doctors around and those that are around must fight against the prevailing conventions of medical ethics, health law, and the bureaucracies of hospitals in order to care for us. In such a world, the very idea of medical ethics is merely a fancy fig leaf covering up quackery. The show is a paean to the dangerous and wonderful potential of the science of modern medicine and a blistering critique of its ethics.



© Neill Hartley, American Historical Theatre

The show has troubled some critics in that it portrays Dr. House as a hero, even though he routinely violates moral and legal rules, obliterates many of the maxims of modern bioethics and health law, and treats patients and colleagues rudely and ruthlessly. He is irascible, insulting, difficult to work with, extraordinarily demanding, and sometimes cruel. On top of it all, he is a shameless and unapologetic narcotics addict. Everything about him is wrong. Dr. House sets himself against humanism, patient autonomy, informed consent, modern hospital organization, and the new techniques of medical pedagogy. In short, he is against much of what we ostensibly advocate in bioethics and many of the ways that we practice and teach.

While he doesn't aspire to today's ideals, Dr. House embodies a more ancient ideal. For House, the doctor has only one job—to diagnose and cure disease. In pursuit of that goal, he must be single-minded, relentless, and uncompromising. Dr. House's team breaks into patients'

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homes to look for causes of illness. They lie to patients and families, test and treat people without consent, blackmail other staff into cooperating, and do so unapologetically and generally without administrative sanction.

In some ways, House is a throwback. When I was a medical student at the University of Pittsburgh in the 1970s, Dr. Jack Myers was the Chair of Internal Medicine. He was famous, like House, for his diagnostic acumen. He rose to become head of the American Board of Internal Medicine. He used to conduct rounds on the wards and oral examinations of candidates for board certification that were notorious for their brutality. He took pride in showing the students how ignorant and incompetent they were. He routinely caused students to break down in tears, and appeared to feel as if this was a sign of his exemplary rigor and effective pedagogy.

House does the same. In one episode, he is teaching a class for medical students. He presents them with a case in which a farmer has been bitten by a snake. The students must decide which type of antivenin to give. If they choose wrong, he says, the patient will die. One student protests,

“Humanity,”  
House grumbles,  
“is overrated.”

“But we can’t be blamed...” House interrupts, “I’m sure this goes against everything you’ve been taught, but right and wrong do exist. Just because you don’t know what the right answer is—maybe there’s even no way you could know what the right answer is—doesn’t make your answer right or even okay. It’s much simpler than that. It’s just plain wrong.” The students aren’t used to House’s blunt and confrontational pedagogy, “You know, it’s kind of hard to think when you’re in our faces like this.” “Yeah,” House replies. “You think it’s going to be easier when you have a real patient really dying?”

Today, Dr. Myers would be hauled before the impaired physician committee, charged with harassment, and either sent to courses on adult learning theory or, more likely, sent for sensitivity training. House, of course, would too. He couldn’t exist in today’s world but, like all fantasies, he begs to be interpreted.

Much has changed since the ’70s in medicine and medical education. Gone are the days of 36-hour shifts and 120-hour weeks. Oddly, in spite of such improvements, neither doctors nor patients seem happier. Editorials in medical journals bemoan the lack of continuity and accountability among the housestaff. Danielle Ofri describes attending physicians at Bellevue Hospital grousing about



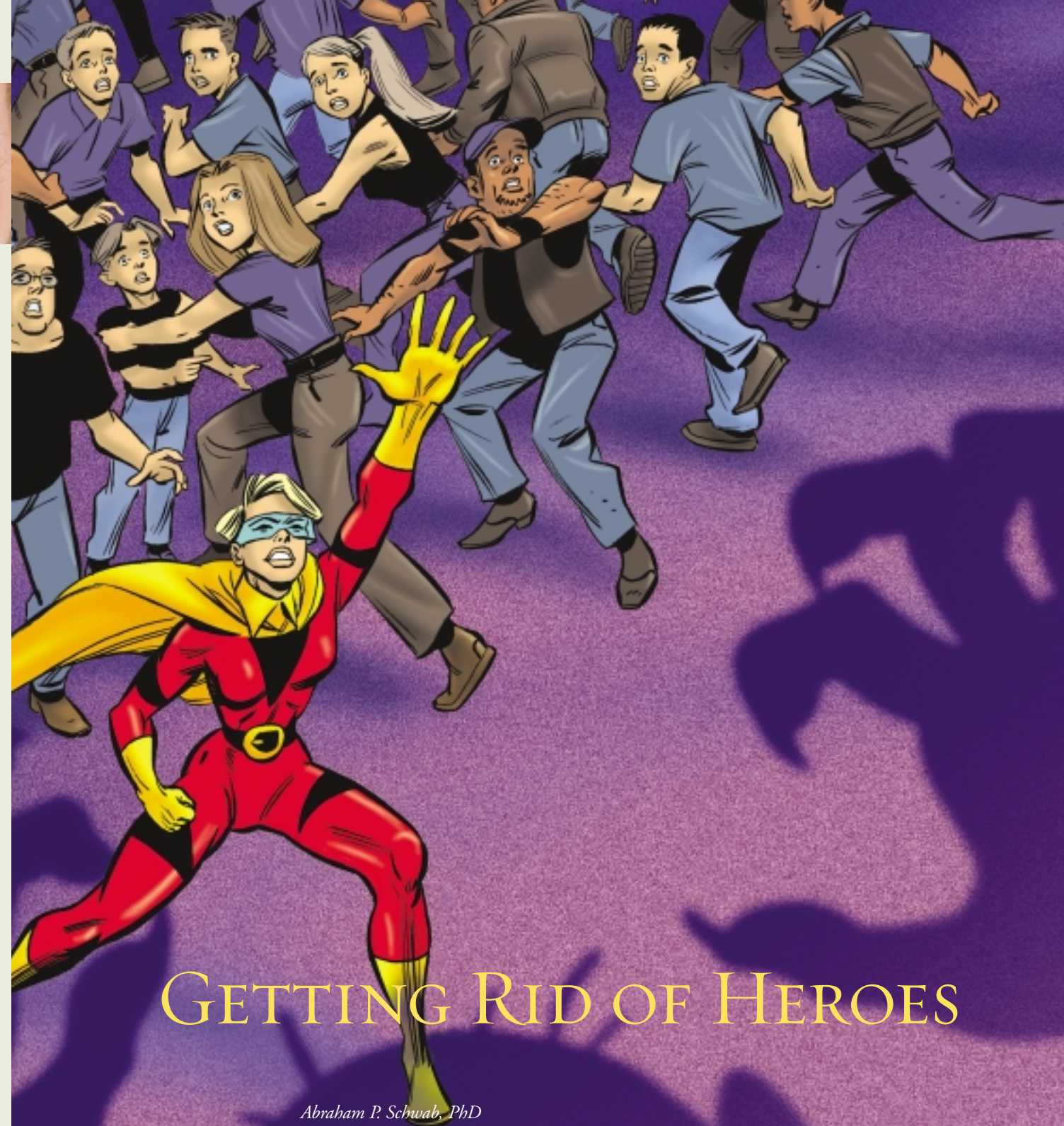
Larsen & Talbert/ Icon International

the new resident call schedules, “Days off to compensate for weekend call? Leaving before every last patient is ‘tucked in’? Missing attending rounds when your cases are being presented? Blasphemy! How dare they change those bedrock rules ex post facto!” Hospitals have become more impersonal. Patients long for, and will pay for, a personal physician. Quality and accountability remain elusive.

Many of the changes have been made in the name of “humanism.” They were supposed to improve doctor-patient relationships, to improve the quality of care, to allow physicians to be both more competent and more caring. *House M.D.* is an implicit critique of all such efforts. In the pilot episode, House is arguing with one of his underlings, Dr. Foreman, who thinks that House has treated a patient rudely and inconsiderately and that such behavior is unacceptable. “Isn’t treating patients why we became doctors?” he demands of his mentor. Dr. House replies, “No, treating illness is why we became doctors. Treating patients is what makes most doctors miserable.” Foreman is shocked. “So you’re trying to eliminate the humanity from the practice of medicine?” “Humanity,” House grumbles, “is overrated.”

House’s character tries to bridge the gap between old shamanistic models of medical care and modern scientific models. House is, first and foremost, a scientist. He is up-to-the-minute on the literature. He remembers every rare disease. He uses all available technology. He is obsessed with finding cures by any means possible. He is Ahab-like in his single-minded, sometimes self-destructive pursuit of the mysterious diagnosis. Like modern medicine, he is dangerous and wonderful. His Dean loves him and hates him. He is a legal and moral risk. He is not the best doctor for every patient. He has no patience for either minor ailments or the untreatable and incurable diseases that make up the bulk of human suffering. But, for the other 10%, the ones where accurate diagnosis is elusive but essential, one would flee from a doctor who espoused professionalism but lacked acumen and long, instead, for the unethical, misanthropic Dr. House.

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## GETTING RID OF HEROES

*Abraham P. Schwab, PhD*

Have you ever walked home late at night, heard footsteps behind you, and loathed the lack of streetlights? Or looked at the bush ahead and worried that someone would jump out from behind it? These worries arise from both the character of the individual you fear will attack you and structural features of your environment. They can be attenuated by addressing the character of everyone on the block ahead (a quixotic goal if there is one), or by adjusting environmental factors, like improving street lighting and bush placement.

Many business models focus on structuring environments to mold human behavior. Think of the uncomfortable seats in fast food restaurants and the narrow aisles of grocery stores—effective environmental features that encourage consumers to get in, get their food, and get out (Katyal 2002). Yet medicine (like most other fields) still seems to favor characterological explanations of behavior over environmental explanations, lauding some individuals as “heroes” and disdaining others as “villains.” For example, Paul Farmer, a physician-medical

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anthropologist who has volunteered extensively to care for some of the poorest individuals in Haiti, is venerated as hero.<sup>1</sup> But inadequate attention is paid to the environments in which such persons act. Circumstances are usually referenced not as an explanation, but as a description of the (often unfortunate) situation within which the individual's character is expressed.

I argue that identifying individuals as “heroes” and “villains” is a mistake arising from a belief that individuals have stable characters. This belief in an (at least relatively) “stable character” should be abandoned in light of the powerful influence environment has on individual decisions and actions.

### The Villainy of Willowbrook

The classic research ethics case of the Willowbrook Hepatitis Studies provides an example.<sup>2</sup> Saul Krugman led a team of researchers who intentionally infected children at the Willowbrook State School with hepatitis from 1956 to 1971. The school was the primary residence of children who were physically and/or cognitively disabled. One interpretation of the Willowbrook Studies assigns Krugman a villainous character: a researcher who misused his position of power to take advantage of an especially vulnerable population with little regard for his subjects' individual interests (intentionally infecting uninfected children with harmful diseases) in order to advance his own career. Even worse, he did so under the cover of ethically appropriate research by getting consent of a sort from parents—early admission to the Willowbrook State School was offered to only those children whose parents would “consent” to the study.

The social and physical environment of the Willowbrook Studies complicates the “villainous” interpretation of Krugman's character. The social environment Krugman operated in—the preference to house physically and mentally disabled children in institutions, and the failure of state funding to match the housing demand—created a physical environment of overcrowding that made Willowbrook a haven for infectious diseases that attacked both residents and staff. Considering this environment, an alternate interpretation of Krugman's character is that he executed his research to improve the lot of existing and incoming Willowbrook residents. Indeed, given his success in limiting the effects not only of hepatitis, but also other infectious diseases like measles, another framing of the story that focuses on lives saved and suffering spared might suggest Krugman had the character of a hero. He improved the lot of a neglected, vulnerable population by applying his expertise in a situation where he had no guarantee of gratitude or reward.

Disagreement about the best interpretation of Krugman's character could persist indefinitely—a bioethicist who advocates on behalf of vulnerable populations may reject the hero interpretation, while one who prioritizes the improvement of public health through the study of medical treatments may reject the villain framing. But even if one character assessment could be proven more accurate than another, as interesting as that discourse may be, focusing on

the classification of character is a mistake. Without the societal predisposition to institutionalize physically and mentally disabled children, the failure to provide adequate funding for these institutions, and the easy spread of infectious diseases in Willowbrook, it is unlikely Krugman would be the subject of any such discussion. Absent these circumstances, there is no classification to make.

### Stable Character

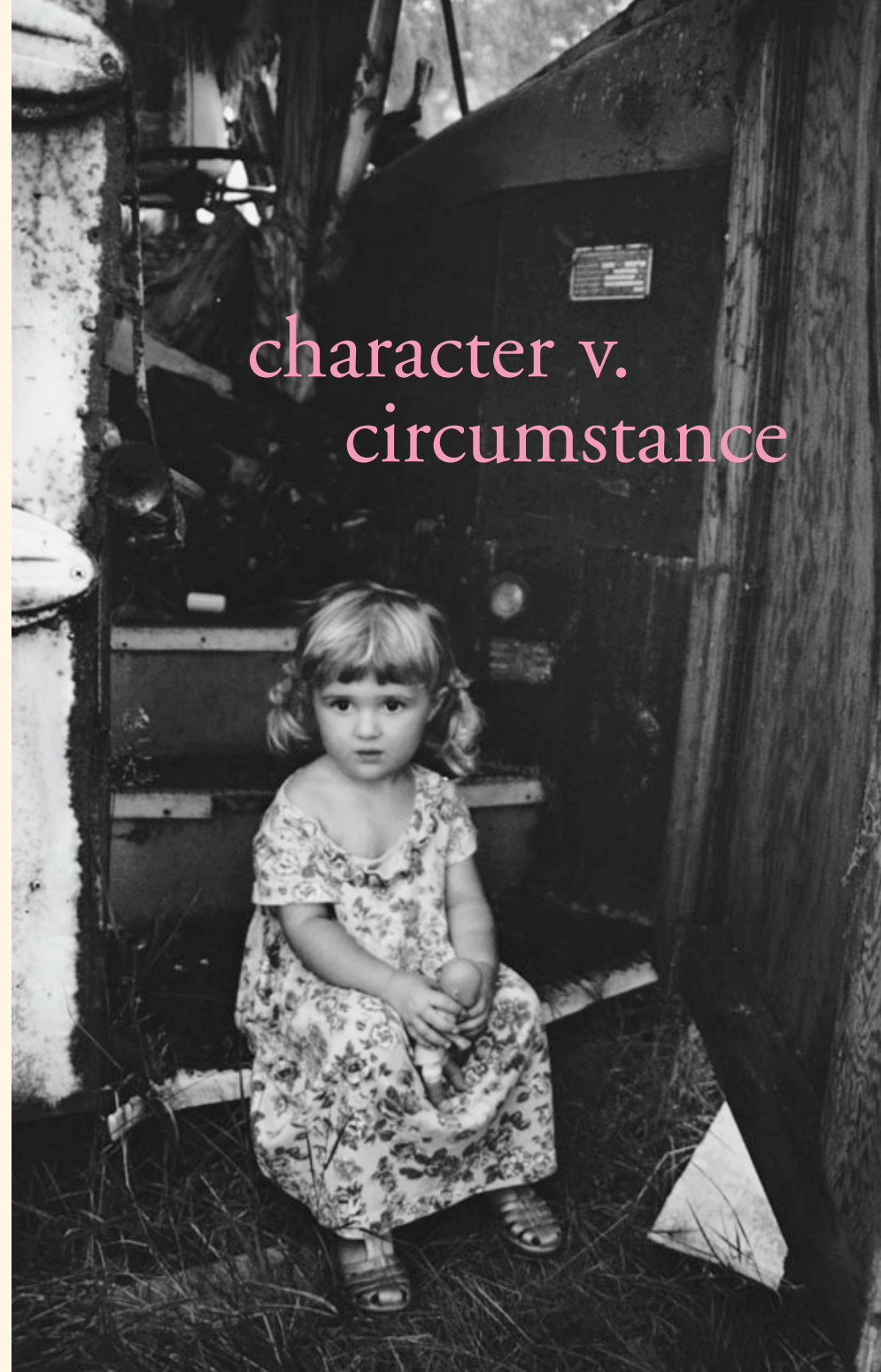
The stable character view says villainy is a characteristic of the individual. On this view, different circumstances produce different expressions of this “stable character,” but relevantly similar circumstances should produce a relevantly similar expression. The stable character view understands the character of the individual to be more or less settled, and stable across time; the shorter the period of time, the more stable the character. It's possible for character to be molded and changed over the long term, but it will not jump about or significantly change as a result of immediate circumstances. Roots for this view may be as scholastic as Aristotle's descriptions of virtuous and vicious characters or as pedestrian as a folk understanding of character. Regardless of source, it assumes Krugman would still be a villain even if he had not worked at Willowbrook or Willowbrook had not been so poorly funded during his tenure—he would just be a villain who lacked the opportunity for villainous actions. The stable character view is not committed to classifying Krugman (or anyone else) as “hero” or “villain,” but it is premised on a relatively static classification.

There's a sense in which the stable character view can never be refuted. It's the same problem with metaphysical deities, or psychological egoism, or free will; no one can prove one side at the expense of the other. I will never be able to definitively deny the possibility of “stable character.” But I can provide evidence that suggests that the stable character view is misleading.

### Evidence Against the Stable Character View

Experiments in social psychology have repeatedly illustrated that behavior is significantly affected by “irrelevant” aspects of the environment—circumstances that should not change how an individual with a stable character would act. A famous example of the influence of irrelevant circumstances on behavior is Milgram's (1963) experiments, in which a research subject was led to believe he or she was giving electric shocks to an individual with a heart condition as part of an experiment investigating the learning process. In around two-thirds of the cases in Milgram's study (and in similar studies afterward), when prodded by an authority figure, subjects were willing to give a shock that would kill the average person. What's disturbing is that the subjects had no independent relationship with the authority figure and their incentive for taking part in the research was a relatively small sum of money (\$4.50 in 1963 or about \$30 today). To avoid harming the “subject,” the actual research subjects only had to ignore the stranger in the room and forgo the money.

## character v. circumstance



A person of good and stable character does not intentionally shock another person to death. (Arguably, a person of average character doesn't do that either.) So an interpretation of Milgram's results that assumes stable character requires us to conclude that most people turn out to have bad character. A more plausible interpretation of Milgram's results abandons the stable character view and concludes that his test subjects were generally people of good character, but their actions were affected by features of the environment like the authority figure in the room.

Darley and Batson's (1973) study of seminary students on their way to a meeting provides more reason to abandon the stable character view, because circumstances irrelevant

to a stable character had a profound effect on these students' choices as well. In this experiment, conditions were controlled to make one set of students late for a meeting, while the other set was on time. On the way to the meeting, both sets passed an individual who was apparently in cardiac arrest. It would seem that being late for a meeting is irrelevant to whether or not a person of good character would help an individual in cardiac arrest, but more of the late seminary students reacted with indifference, walking past someone who appeared to be in grave danger.

Even if one accepts the premise of “stable character,” these studies show that irrelevant circumstances still affect the actions of such persons. In the Darley and Batson study, the subjects who were on time were more likely to help the individual in need. Even if most people have bad character, more of these bad characters help when they are not pressed for time. A study by Isen and Levin (1972) supports this point. They found that finding change in a phone booth led more people to help someone who dropped their papers on the ground. Even if we assume character is stable, apparently finding a dime convinces bad characters to help a stranger.

Therefore, advocates of the stable character view at minimum must admit that circumstances can mold the expression of “stable character,” and therefore even they must concede the value of controlling the circumstances under which people are acting.

### Getting Rid of Heroes

To change or explain villainous behavior, I think we should look to environment, not character. Tempting as it might be, I also think that controlling the environment to produce “heroic” actions would be equally misguided. Instead, we should try to control environments to avoid the need for these actions. Paul Farmer's heroics only arise in certain undesirable circumstances. Specifically, the destitution and poverty that pervade Haiti's economic and medical infrastructures make his “heroic” actions possible. Progressive medical schools might be proud to produce more Dr. Farmers who will volunteer so much of their time. Instead, emphasis should be on eliminating the need for his “heroic”

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actions by changing the economic infrastructure that deprives so many Haitians of basic medical care.

Perhaps stable character and the concepts of hero and villain have something else in common with metaphysical deities, psychological egoism, and free will: believing in them can serve an important social function even if they are not true. Describing a “villain” can help us communicate the obstacles to the good life and describing a “hero” can communicate what we want people to emulate. But even if these concepts are shown to be necessary conditions for providing us with the best life, discussions of heroes and villains should be symbolic rather than descriptive, relinquishing the idea of stable character. Attributing an individual’s activities to his or her character distracts from more important goals: identifying and avoiding situations that produce “villainous” actions and those that require “heroic” effort.

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## Notes

<sup>1</sup><http://www.myhero.com/myhero/hero.asp?hero=Farmer>

<sup>2</sup>One review of the details of Willowbrook can be found in Rothman and Rothman (1984). Also see Krugman’s (1986) defense of his actions in light of the criticisms.

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Blockbuster drugs were forged through a synergy of the new script-tracking technology and consumer demand. Direct-to-consumer (DTC) marketing empowered patients to negotiate their own prescriptions during clinical encounters with doctors, and the blockbuster era of pharmaceuticals created “Generation Rx” (Critser 2005), a new generation that knows how to get the medication it wants. Big Pharma has helped to socialize and train (“script,” if you will) patients on how to obtain their own prescriptions: see TV ad, look up product on Internet, complete “symptom checklist,” print out symptom check list, bring symptoms on paper to doctor, ask about this brand name product, and receive the prescription that you want around 50 to 70% of the time. What should alarm doctors is that their role in this total system of prescription generation is being reduced further and further to no more than a script writer. In a post-Viagra world (Viagra being the paradigm of DTC) the consumer has become the wild card and often the stimulus for prescription generation. Although the hero-villain binary is never quite that black and white, it nonetheless remains worth exploring from a critical perspective. Patient demand for high-priced, brand name pharmaceuticals may pose the biggest threat in the future for safely and ethically prescribing medication.

Therefore, licensed script writers interested in taking back the script must not focus exclusively on achieving more transparency in pharmaceutical industry practices; they must also find ways to effectively (and ethically) interact with patients who demand their own script for Brand X, often with a coupon for “a free trial.”

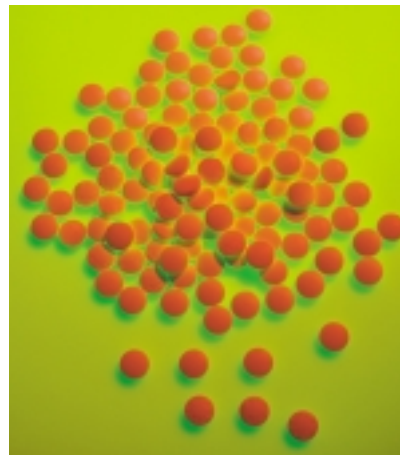
This prescription “partnership” between doctors and patients (forged via the efforts of Big Pharma) may be the most villainous thing to ever happen to the script pad, and I’m quite certain it will take heroic efforts to untangle it in the future.

*Michael Oldani is Assistant Professor of Medical Anthropology at University of Wisconsin-Whitewater. He is currently working on an ethnographic manuscript regarding pharmaceutical families, or “phamilies.”*

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# Highlights for Bioethicists

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## Goofus and Gallant



Goofus runs a “slow code.”



Gallant holds as many meetings as it takes to wear the family down and get a DNR.



Goofus gives institutionalized children radioactive oatmeal and tells them they’re in the Fernald science club.



Gallant gets ethics committee approval and informed parental consent before giving a cognitively impaired six-year-old growth-retarding hormones and removing her uterus and breast buds.

—KW



Kate Bosher, PhD and Katie Watson, JD

2,500 years ago, the Hollywood of Greece didn't depict simple heroes and villains; it dished up authentic human complexity. In the theatre of Dionysos, Athenians came together to watch plays that offer no simple moral compass and no obvious solutions. So it's fitting that last fall, Dionysos brought us together for Greek theater in the back of the tiny Hideout bar. Kate Bosher came to watch Katie Watson's three one-act puppet shows: adaptations of *Hecuba*, *Lysistrata*, and *Persians*. A classics professor, KB was preparing to launch a faculty colloquium on Aeschylus' *Persians*, and she couldn't imagine what a nice text like this would be doing in a place like that with someone from the medical school. Aeschylus was a soldier in the war against the Persians, yet in this tragedy he adopted his defeated enemy's point of view. *Persians* seems to be a meditation on tyranny addressed to all who aspire to oppress—his countrymen included. Afterward KB joined cast and audience in a discussion of the applicability of these Greek war plays to our invasion of Iraq. The following week, KW joined the classics colloquium.

Fifth-century Greece held popular playwrights in high esteem as the teachers of the city: *didaskalos* meant both teacher and theatrical director. The plays still teach. Greek tragedies depict impossible choices, good people wrecked by circumstance, and the burden of belated understanding—all characteristics of modern medicine. Should the life of one wounded man be risked to save the whole group

(*Philoctetes*)? What might follow a wife's disengagement from her husband when he kills their child (*Agamemnon*)? How might

we both honor and protect a hero whose mental illness has rendered him a potential danger to himself and others (*Ajax*)? This spring KW began her law class for the MH&B Program's first cohort of MA students by assigning *Antigone*. With the theme of *The People's Court* pumping in the background, students assumed the play's characters and jumped up to argue with their family members. Afterward, it served as a Rorschach test for students' values. Who is sympathetic with Antigone's defiance of the law in allegiance to family and religion, and who thinks King Creon has the harder choice? The analysis of individual v. collective needs, religion v. state, duties to intimates v. obligates—unmoored from contemporary manifestations of those conflicts, *Antigone* launched medical students into the quandaries of constitutional law.

We think Freud isn't the only physician who might find Greek tragedy helpful, but in an accidental homage to that synthesizer of our two fields, the MH&B Program ended the year by taking some medical students to see *Oedipus Complex*, a new play combining Freudian text and *Oedipus Rex*. Because answers are not only to be found studying texts, but also by loosening our minds a little and giving in to the chaotic tragedies offered to Dionysos so long ago.



ATRIUM welcomes unsolicited submissions. The theme for the next issue (Spring 2008) will be "Unmentionables."

For more information, visit [www.bioethics.northwestern.edu/atrium](http://www.bioethics.northwestern.edu/atrium).

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