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MYTHS AND MISCONCEPTIONS IN BIOMEDICAL ETHICS
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Thank you very much for the kind introduction, Dr. Margolis. I’m truly honored and grateful for having been invited to be the Waggoner Lecturer for 2013. Previous speakers in this series are an illustrious group, and I hope to live up to the high standards they’ve set.

Some of you know that I’m a native of Boston, which I called home for 37 years. Although I’ve been living in Charleston for 38 years, I’ve remained a loyal fan of Boston sports. The last decade has been incredible for Boston. The Celtics won their 17th NBA Championship, in 2006, their first in 22 years, thanks to the “Big Three.” The Red Sox finally broke the “Curse of the Bambino” by winning their first World Series in 86 years in 2004, and have added two more since. And the Patriots won the Super Bowl for the first time ever in February, 2002, with a thanks to the University of Michigan for sending to us their quarterback, who led the Wolverines to victory in the Orange Bowl, over always tough Alabama, in 1999. We got him at the end of the 6th round, the 199th pick in the NFL draft and he became the fourth string quarterback with the Patriots. In his second season, Tom Brady replaced the injured Drew Bledsoe and led the Patriots to the championship in Super Bowl 36, and two more NFL championships after that. So, from this Bostonian, a great big Thank You to the University of Michigan.

So, to get to the topic at hand: The history of medicine is filled with misconceptions and myths that in retrospect have been surprisingly persistent both in science and in ethics. The history of medicine has been described as a "grand narrative of progress," but that may be the biggest myth of all. There was virtually no progress in our understanding of human physiology from the time of Galen in the second century AD for nearly 1500 years, when modern medical science began with the experimental investigations of William Harvey on the circulation of blood, published in 1628.

Scientific progress after that point was nearly continuous, as depicted in this partial list of scientific achievements in the 18th and 19th centuries, but that wasn’t true of clinical medicine. The practice of medicine continued to be mired in the ancient myths and misconceptions of Hippocrates and Galen for more than 200 years after Harvey’s seminal work. Textbooks of medicine were essentially restatements of Hippocratic and Galenic therapies until the late 19th century. For example, the Hippocratic therapies of bloodletting and cauterization persisted for 2,000 years. Bloodletting was still in common use well into the 19th century.

Although modern scientific investigational methods were introduced in the 17th century and still flourish, modern clinical practice arguably didn’t begin until after Louis Pasteur’s publication of his studies of germs in 1861 and Joseph Lister’s incorporation of these ideas into the clinical practice of antisepsis in 1865.
Lister documented decreased infection rates when carbolic acid antisepsis was used during surgery, shown here as carbolic acid (what we now call phenol) is being sprayed on the surgical field. The persistence of misconceptions in medical practice is illustrated by the fact that Lister's antisepsis was not generally accepted and his methods were not widely adopted for decades, because the idea of bacteria and antisepsis was mistakenly believed to be wrong-headed in the medical and surgical communities. Lister's experiences were well known in the United States because his ideas were refined and popularized by William Halsted of Johns Hopkins, shown here with another giant of 20th century surgery, Harvey Cushing. Nevertheless, it took over 40 years for antisepsis in surgery and the consequent reductions in infection rates to become widespread in this country. I'm sure you can think of other examples of slow adoption of successful new medications, technologies, and methods in your own field.

Myths and misconceptions have been as widespread in bioethics as they've been in science. Maybe the most persistent misconception originated with Hippocrates, who said this some 2500 years ago: "Perform these duties calmly and adroitly, concealing most things from the patient while you are attending to him... revealing nothing of the patient's future or present condition." Underlying this instruction was the mistaken belief that patients are harmed by knowing the truth about a bad prognosis, that is, by hearing bad news. It wasn't until the late 20th century that this paternalistic culture changed.

For example, a survey of physicians that was done in 1961 asked this: "The following questions apply to your policy about telling patients they have cancer. For the purpose of this questionnaire, assume that the diagnosis is certain and that though treatment may be possible the eventual prognosis is grave." “What is your usual policy about telling patients?” 88% of the responses were not to tell the patient. The same question was asked in a survey of physicians in 1979. This time the answer was to tell the patient in 98% of the responses. Clearly a major cultural shift had happened. It was based on the realization that most patients actually benefit and prefer to know the truth about their condition and their prognosis.

Lots of other myths and misconceptions are common in medical ethics. Although we're doing a lot better about being honest with patients, many physicians still have trouble dealing with the emotional stress of delivering bad news, so we tend to avoid doing it, on the pretext of protecting our patients.

A large majority of physicians believe, “Gifts from industry influence the prescribing practices of many of my colleagues, but they don’t influence mine.”

“Industry controlled continuing medical education biases the practice of many of my colleagues, but I personally am untouched.”

“I deceive insurance companies only to benefit my patients — I don’t do it to serve my own interests.”

There’s a widespread belief that informed consent exists on a form signed by a patient, and
that this form is ethically necessary. Many residents believe this, especially surgical residents who get patients to sign operative permits every day. As clinicians, we believe that the informed consent form is ethically necessary and often don’t realize that it’s only a piece of evidence to be used in a courtroom if it becomes necessary; informed consent is a process, not a form.

When we declare a potential organ donor dead by either brain criteria or circulatory criteria, we believe that the patient is actually dead, and legally, they are. But the death of these patients is arguably a legal fiction that’s designed to allow donation of viable vital organs by satisfying the Dead Donor Rule. The debate over abandoning the Dead Donor Rule has heated up in recent years; the most recent salvos were fired in the New England Journal of Medicine just a month ago, in the October 3 issue.5

In a move that demonstrably decreases the availability of organs for transplantation, we accept the misconception that altruism is and should be the only acceptable motivation for organ donation. This misconception has cost the lives of thousands of patients with end organ failure: over 10,000 patients in 2012 alone.

Finally, there’s a misconception that health professionals are guided by a single set of ethical principles that apply throughout the field. This mistake can have serious consequences for both the care of patients and the operation of hospitals.

I have only a limited time to talk about myths and misconceptions in biomedical ethics, and we could go on all day with this list. But I’ll spend the rest of the hour talking about only two of them: the myth that altruism is the sole acceptable motivation for organ donation and the misconception that certain ethical principles are of equal importance for all health professionals.

I’ll start with the myth that altruism is the sole acceptable motivation for organ donation. I’m going to argue that this policy was built on soft ground from the beginning and that prohibiting the use of economic incentives for organ donation is an incoherent, unjust, and lethal policy.
This graph depicts the fundamental problem with organ donation and transplantation. Taking 1995 as the base, the rate of growth of the waiting list for organs has grown at a linear rate that’s 3-1/2 times faster than the rate of increase of deceased donors. While the waiting list and deaths continue to grow, the number of donors has essentially stabilized over the last seven years. This accounts for what’s come to be known as the organ gap. Economists from the University of Florida and Auburn University have calculated that it would take on the order of $1000 of financial incentive per donor to reduce the waiting list to essentially zero over a period of a few years.

Why don’t we simply do that? There are reasons, and, in my view, they’re not good ones. In fact, I believe the origin and continuing existence of our dysfunctional organ procurement system is founded in both myth and misconception, as I’ll explain now.

Motivation is important in determining what people do. The National Organ Transplantation Act of 1984 made it a federal felony to provide or accept any "valuable consideration" for an organ. Thus, over the last 30 years, the only motivation that’s legally acceptable is altruism, that is, providing organs for no reward other than the satisfaction of doing something good. But is the reasoning underlying this view justified? In my view, this position is based on misconceptions, namely, that payment is intrinsically wrong because it violates justice, and that payment for donated organs would exploit the poor.
These misconceptions have led to what amounts to a massive loss of life over the last few decades. The number of deaths on organ transplant waiting lists exceeds the number of Americans killed in action in the Korean War and the Vietnam War. We passed the 123,000 dead from the Hiroshima atomic bomb in 2009. The death rate has shown no signs of slowing down over the last few decades, as you've already seen.

When people are restricted to only one acceptable motivation to donate organs, they find many reasons not to donate.

- Many think that bodies should be buried intact, based on their religion or personal beliefs.
- We all avoid thinking about or confronting the loss of loved ones and certainly our own mortality.
- In some communities there’s a distrust of the medical community that seems entirely justified on historical grounds, such as the horrific 40-year Tuskegee study, which understandably still influences the attitudes of many in the African-American community.
- Some believe that allocation is inequitable and some mistakenly believe that transplantation is ineffective.
- There’s widespread misunderstanding of what brain death means — “The doctors say Uncle John is dead, but he looks exactly the same as he did yesterday when he was

still alive; is he really dead?"

- And there are serious stresses at the time of the sudden unexpected death that’s always true in the case of organ donors whose brains were severely damaged by a catastrophic medical event such as stroke or a ruptured aneurysm, or severe head trauma.

What about reasons to motivate donation? When there’s only one acceptable motivation to donate — service to others — We’re not all angels, so it’s not surprising that half of the potentially available organs are buried or cremated.

By way of history, the first successful human transplant took place at the Peter Bent Brigham Hospital in Boston in December 1954, when a kidney was transplanted from an identical twin into his brother. Joe Murray, the surgeon and researcher, won the Nobel Prize for Physiology or Medicine in 1990.

Because of problems with immune rejection, the field of transplantation developed slowly after that. In 1968, the first version of the Uniform Anatomical Gift Act, which intended to help increase organ donation, had no ban on selling or buying organs, although the matter was discussed and no consensus was reached. Cyclosporine was tested in 1979, and came into clinical use in 1982. It was the first truly successful immunosuppressive agent.

Transplant developed rapidly after that and became a growth industry. A Virginia physician, Dr. Barry Jacobs, proposed that financial incentives be provided to deceased donors, and saw the need for someone to serve as an intermediary between people who wanted to donate and those who needed an organ, so he set up a brokerage firm for organs. At the same time, a committee of the US House of Representatives was drawing up a bill that came to be known as the National Organ Transplantation Act. The committee members were so outraged at the idea of buying and selling organs that they added a draconian clause to the bill that forbade any "valuable consideration" for donating an organ. This clause disallows all incentives for donation other than a good-hearted public spirit, excluding such incentives as paying for funeral expenses, tax credits to the estates of donors, and other potential incentives, in the belief that the harms of incentives substantially outweighed the benefits.

Let me illustrate how counterproductive the prohibition is, with a story about a problem we had when I was Medical Director of LifePoint, our state’s Organ Procurement Organization. We had a potential organ donor who was brain dead after a fall from a ladder, and was an undocumented alien from Mexico. When we were finally able to reach his family in Mexico City, they were willing to consent to organ donation, but only on the condition that we pay for transporting his body back to Mexico — his body minus a heart, 2 lungs, 2 kidneys, and a liver — at a cost of about $3000. We couldn’t do it, because paying for repatriating a body is a “valuable consideration” and would therefore be a federal felony. Six people died on waiting lists because the man’s organs were buried rather than transplanted. When the same thing happened a year later with a potential donor (from Michigan, as it happens), I was able to persuade the OPO administrators that we ought to just do it. This, of course, was a clear violation of NOTA, but neither I nor the OPO was
worried about prosecution. No prosecutor was likely to pursue the case, and for sure, no jury would convict on the basis of paying $3,000 to save multiple lives. I haven’t counted how many patients we ultimately saved while committing federal felonies.

The balance of harms and benefits of organ donation have changed a lot in the last 30 years. For example, in a well-known and often cited book in 1972, The Gift Relationship, Richard Titmuss argued that paying for blood donation was not a good idea because it provided an incentive to lie about infection with hepatitis B virus, which would lead to an increased infection rate in the blood pool. He also said that payment was going to lead to a decrease in donation. There was only anecdotal support for these assertions, but Titmuss’s work has been repeatedly cited as an important reason not to allow payment for organ donation.

A review of the recent literature from 2001 through 2012 was published in Science this past May, and provided strong evidence from several controlled studies that economic motivation increases blood donation, with no increase or change of any kind in the infection rate. There was zero evidence of a decrease in motivation to voluntarily donate blood. Because of NOTA, it’s not possible to do any direct studies of financial incentives for organ donation without a waiver by an act of Congress, but these recent studies suggest that some of the most frequently cited arguments against allowing financial incentives have been purely mythological.

A case can easily be made that tax credits or paying for funeral expenses should be allowed as incentives for deceased donors. But I’m going to make the much tougher case: paying cash to motivate living donors to provide kidneys, by regulating the price of the incentive at some nonzero level that’s sufficient to meet the need for organs. I hasten to point out that when financial incentives are available to donors, it’s still perfectly possible to have altruistic donation, for example, to family and friends, and also to strangers. Designated donation, that is, naming a person to whom your kidney should be given, would also not change. Since I’ll be talking about living donors, I’m going to focus on kidney donation.

I’ll make the case for paying people to donate a kidney starting with a few claims. First, is the Donation Is Good claim, which I’ll designate as DG — meaning that donating a kidney is both legal and is praiseworthy. The second claim is that Payment for Tissue is OK, which I designate as PT-OK, since we don’t have a problem with payment for sperm, eggs, or hair. We also don’t have much of a problem with paying for blood donations, which isn’t particularly praised, but also isn’t awful. While there’s a huge difference in pain and recovery time, there appears to be no morally relevant difference between donating blood and donating a kidney.

So, my prima facie case is this: if my two claims — Donation Is Good and Payment for Tissue Is OK — are true, then paying people to donate a kidney is not problematic.

I want to explain why the ban on financial incentives for kidneys, which I’ll call kidney sales, is inconsistent. If we oppose selling kidneys because it’s too dangerous, then we ought to oppose kidney donation as well.
But we don’t oppose kidney donation because we know that the risk of donating a kidney is very low. So it’s inconsistent to oppose paying for a kidney because it’s dangerous and at the same time support the idea that donation is a good thing.

If we oppose paying for kidneys because we shouldn’t sell body parts, then we ought to oppose commercial blood banks. But we don’t oppose commercial blood banks because by producing blood components, they save lives. Therefore, it’s inconsistent to both oppose kidney sales and support paying for tissue donation. To be consistent, we have to support paying for kidneys.

There are two main objections to this prima facie case. They are that paying for kidneys is intrinsically wrong because it’s unjust, and that paying for kidneys would exploit the poor. Let’s consider first the assertion that paying for kidneys is unjust.

Respect for autonomy is a principle that’s highly regarded in both law and in ethics. There are two ways of thinking about autonomy — the first is that autonomy consists in making decisions rationally, what we might call the "thick" version. Here, autonomous acts are those in which the choices that are made are consistent with self-respect and one’s own humanity. The thin version of autonomy holds that autonomous acts are those in which choices are made without interference by others, no matter the rationale underlying the choice.

Now, the law protects autonomy in the thin sense because law is not used to enforce self-respect or humanity. For example, in the process of informed consent, the goal is to prevent imposition of a thick morality — patients can make any choice they want. So protection of autonomy that comes from the thin version supports the selling of kidneys.

Also, even if the law were to protect autonomy in the thick sense, that is, respect for one’s dignity and humanity, our humanity is not vested in every one of our essential body parts. Rather, our humanity comes from our mind, located in our brain, not from our kidneys. Removing a kidney doesn’t affect our overall well-being, and it doesn’t affect our essential humanity.

To many people, the prohibition on paying for kidneys is justified because motivation by money indicates greed, and our emotional response to greed is revulsion. But observe that the seller’s motivation could be noble, because she could be motivated both by saving a life and paying, for example, for her child’s education. Also, the unpaid donor’s motivation could be anything but noble; for example he could be motivated by an irrationally low self-worth or by a desire to generate indebtedness in order to manipulate someone else. The impulse to do good is not binary — it’s not either there or not there. Motivation is highly variable. And law, such as NOTA, is too blunt an instrument to separate noble from base motivation.

The arguments that intend to show that paying for kidneys exploits the poor often use the fact that there’s an international black market in kidneys, in which wealthy people from
industrialized countries pay for organs that are of uncertain quality, and the donors from the Third World are poor people who desperately need the money — but after they donate a kidney, they go back to a miserable life in which there’s little or no follow-up care. These practices are and should be condemned.

But where do black markets come from? They appear when free markets are suppressed, and a regulated market for organs would do precisely the opposite — it would prevent a black market. In this country, transplantation is safe and medical care is sophisticated. There’s careful screening and selection of donors and follow-up care is standard for all donors regardless of economic status. What I’m suggesting is a regulated market: the amount of the payment for a kidney is predetermined. There’s no bazaar with people standing on street corners selling kidneys to the highest bidder. Rather, allocation of organs remains as it is today, through the United Network for Organ Sharing. Only the donation side would be affected.

The exploitation argument also suggests that although the financial benefits would be equal for the well-off and the poor, the burdens are unequal, because the poor are desperate, which makes paying for kidneys unreasonable and irrational. The seller is coerced into selling a kidney, so the argument goes, and the market exploits that vulnerability. But if it’s true that donation is a good thing, then paying for kidneys may be reasonable and rational because the poor seller may gain exactly the same satisfactions as the unpaid volunteer donor, but in addition get a financial reward for doing so.

It’s also argued that financial incentives for kidney donation is a slippery slope because commodification of body parts will lead to degeneration of the social fabric. It’s been argued that paying for a kidney will lead to the breakdown of generosity and friendship and love, but consider that most donations are between family members, while most sales are likely to go to strangers. Furthermore, people who receive money for a kidney are unlikely to love their family or friends less or to be loved less because of accepting money.

If the arguments for prohibiting the sale of kidneys are so weak, why is there such widespread support for them? I believe it’s because selling a body part produces an emotional response — repugnance — which generally resists rational argument. Yet if we consider repulsive ideas and technologies of former times, we see that they often have led to valuable outcomes, such as transplantation itself and in vitro fertilization that were vilified at one time, as was the threat of recombinant DNA research to human health, which led to the formation of the Recombinant DNA Advisory Committee, the RAC, of the 1970s, charged with reviewing and approving all recombinant DNA experiments. Yet the revulsion that was felt toward recombinant DNA research resulted in therapies of major importance, such as the creation in the laboratory of human insulin, streptokinase, human growth hormone, erythropoietin, hepatitis B vaccine, human interleukin, alpha and gamma interferon, Factor VIII, and 500 other therapies that are used widely in treating serious diseases.

In considering the issue of prohibition of any valuable consideration for organs for transplantation, we shouldn’t ignore the whole story. The donor is only half of it. The other
half is the 10,000 people on the waiting list who died last year because not enough organs were available to replace their failing vital organs. In my view, those who support the ban on payment for organs have to bear some degree of moral responsibility for those thousands of deaths that could be prevented by motivating millions of people who have two kidneys but need only one, to give up one of them in exchange for around $1000 to $5000.

I’ve already talked about some issues of justice. There are lots of different views of what justice is, but one widely held view, certainly in this country, is that justice means equal treatment under the law. With regard to organ transplantation, it’s interesting to note that everyone in the system, from beginning to end, is paid for what they do, including organ procurement organizations, surgeons, hospital employees, and drug and device companies. With one exception. The one participant who’s critical to the transplant process is the source of the organ, the organ donor, and it just doesn’t make sense that everyone in the system is paid except for this key participant. Justice demands that organ donors should be paid for their critical contributions.

All efforts to increase organ availability in our purely altruistic system have failed. The current system is based on myths and misconceptions — the 40-year-old myth that paying for blood donation decreases voluntary donations and contaminates the blood supply. It’s based on the misconceptions that payment for organs is intrinsically wrong because it’s unjust and it exploits the poor, none of which holds water. A system that provides financial incentives would not only substantially increase the supply of organs, saving thousands of lives every year, but it’s ethically preferable to the donation system we currently have and, even more importantly, it would eradicate all of the rationing problems that comprise 90% of the ethical dilemmas of transplantation by wiping out the waiting list, which now stands at 120,000 patients at risk of early death.

Both law and bioethics in this country place a high priority on human well-being and autonomy. If we intend to be truly serious about these values, then a regulated market for organs is not just acceptable, it’s a moral imperative.

The following words were written over two decades ago and are stunningly prophetic about the outcomes in our current system: “We have never encountered a single policy more at odds with public welfare than the current altruism only organ procurement policy in the United States... If the current policy is maintained the shortage will continue to grow worse as will the needless suffering.” This is from the Yale Journal of regulation 1991. As long as we continue the current policies, the slope of these lines won’t change, the death rate will grow.

**Ethics for the Emerging Health Care System**

I’m going to change gears now and talk about something a little more abstract. A few months ago, I was asked to address my medical school’s faculty on the topic, “Ethics for the Emerging Health Care System.” In that talk, I identified two misconceptions: that all health professionals are guided by a single set of ethical principles, and that the shape of the
health care system will be determined by the Affordable Care Act. I’ll place the ethics of health care in the context of the huge changes that the ACA has brought about and is going to continue to bring about in the next few months and years. We don’t know what the emerging health care system is going to look like down the road because of the current political climate and because, like Yogi Berra, I think, “It’s difficult to make predictions, especially about the future.” Anyone who predicts the form of the emerging health care system is likely to follow in the footsteps of Charles Duell, US Commissioner of Patents, who said, in 1899, "Everything that can be invented has been invented."

And don’t forget Harry Warner, one of the Warner Brothers, who famously said, in 1927, the era of silent movies, "Who the hell wants to hear actors talk?" Or, Dr. Stephen Paget who wrote about my own field, in his book, The Surgery of the Chest, in 1896, in the opening sentences of Chapter 10, Wounds of the Heart: "Surgery of the heart has probably reached the limits set by Nature to all surgery. No method, no new discovery, can overcome the natural difficulties that attend a wound of the heart." ... So much for open heart surgery.

Or, Dr. Lee DeForest, the electronics pioneer, so-called “Father of Radio,” who said, in 1967, " Man will never reach the moon — regardless of all future scientific advances.” Two years later, Neil Armstrong was walking on the moon. So ... no predictions from me about the future form of our health care system.

Now, I said that it’s wrong to think that there’s a single ethic for all who work in the health care field and that the shape of the health care system will be determined by the Affordable Care Act. Here’s what I meant by that.

It’s not news that the health care enterprise is very complex and has a lot of different players, including clinical professionals, teachers, scientists, and administrators. Each of those groups has different purposes and goals, and each works toward achieving those goals guided by ethical principles. Of course, in pursuing our goals, we have to stay within the law, and, in health care, federal law is going to determine the health care system’s broad outlines.

But it’s important to realize that the law isn't the only determinant of the shape of the emerging health care system. Regardless of the successes and failures, of the ACA, we workers in the trenches of health care will still be responsible for caring for patients, maintaining facilities that we use to provide that care, teaching and training future generations of health professionals, and innovating and discovering toward enhancing our ability to prevent and cure disease. Each of us will also help to shape the coming health care system, guided not only by the law, but even more by our respective ethics.

I say “respective ethics” because I believe that there’s not a single health care ethics to guide decision making. Rather, I believe that there’re different ethical guides for at least four distinct groups — clinical professionals, teachers, research scientists, and hospital administrators. It’s not unusual for one person to serve in more than one of those roles, or even all four, all at the same time. Back in my callow youth 25 years ago, I was at the same time a practicing pediatric cardiac surgeon, a teacher of medical students and surgical
residents, a research scientist, and Medical Director of the University Hospital. According to the AMA's Code of Medical Ethics, I had the same ethical obligations in all those positions. Here's what it says:

“Assuming a title or position the removes the physician from direct patient-physician relationships does not override professional ethical obligations... Adherence to professional medical standards includes ... placing the interests of patients above other considerations, such as ... employer business interests.” I think this is a misconception. I'll explain why.

But first, I want to be very clear. The ethical principles for clinicians, teachers, researchers, and administrators are the same—we’re all human beings, and each of has a human nature that requires certain kinds of responses to daily challenges. But, although the principles are the same, their order of importance is critically different, because the problems that each group faces are different. Let me back up and explain.

Every day, each of us has to make thousands of choices, from deciding whether it's healthier to use butter versus margarine on our toast for breakfast to whether to recommend medical treatment versus open heart surgery to a patient with coronary artery disease, or whether life support has become futile and it’s time to discontinue the ventilator. To navigate those choices successfully, we need certain principles as guides. A partial list of the principles that’re important for all of us includes respect for the right of every patient to decide what happens to their own bodies, honesty in all professional interactions, integrity, that is, consistency between what we believe and what we do, workplace competence, compassion for suffering patients, and an attitude of benevolence toward others. But, the precise order of importance for the various principles, and these are only a few of them, is different for the different groups. That’s because their goals and the problems they face are different. I’ll describe what I mean for each of the four groups.

Hospital administrators are basically business people, so their ethical principles are essentially business ethics. To understand the relative importance of principles for administrators, we have to know, what’s the goal of the business of maintaining hospitals. The central goal of hospital administrators is to preserve the hospital's long-term existence and flourishing. Given that, what does it take to preserve long-term existence? Well, for patients to be willing to come for treatment to my hospital or to yours, they have to trust that the hospital will treat them honestly, fairly, and respectfully, exhibiting what some have called “common decency”. Administrators have the responsibility to make sure that their staff relates to patients in those ways.

Hospital administrators have to deal with problems related to the financial balance sheet. They have to keep revenues and expenses in relative balance in order to ensure long-term survival of the institution. Also, they have to create and enforce policies so that the hospital can accomplish its mission.

These administrative responsibilities aren’t easy. For example, Emory University and its hospitals lost a huge amount of trust when a scandal erupted 4 years ago. Dr. Charles
Nemeroff, chair of the Department of Psychiatry, was revealed to have accepted over $2½ million from drug companies ... while publishing papers and speaking on behalf of the companies’ products. Clearly, Nemeroff handled his conflict of interest poorly. But, the university administration made it much worse by stonewalling the investigation. Administrators had an unambiguous responsibility to oversee conflicts of interest like this, they knew about Nemeroff’s conflicts of interest for several years, yet they abdicated that responsibility.9 A number of similar scandals at the university level have taken place in recent years, for example, at Harvard, the University of Pennsylvania, the University of Wisconsin, and UAB.

The hospital’s primary goal is its continuing existence and flourishing in the long term, so the administrator’s role requires that their foremost ethical principles have to be to ensure honesty, fairness, and common decency.

The activities of science have an entirely different goal: the discovery or creation of new knowledge. Like all human beings, scientists should be benevolent toward others and have compassion for the human condition. But the ethical principles that’re most important for successful achievement of the goals of science are not beneficence and compassion — they are integrity and honesty. Without absolute honesty and integrity in designing, conducting, and reporting results of their studies, the foundations of science can be undermined and even destroyed.

Right now, those foundations are at risk because of pockets of ethical wrongdoing in the biomedical sciences. A recent study of several thousand early- and mid-career scientists asked whether they personally had engaged in any of 10 seriously unethical practices, including, for example, falsifying or fabricating research data. Fully 33% of the respondents admitted they had engaged in at least one of those 10 egregious behaviors in the previous three years.10

Research misconduct of this magnitude seriously endangers the foundations of science, and, worse than that, they pose risks to patients whose doctors and other clinicians will be making patient care decisions that are based on false information.

These disturbing studies clearly show the critical importance for scientists to base their day-to-day behavior on the ethical principles of integrity and honesty, regardless of external pressures.

Teachers and trainers of future physicians, nurses, technicians, and other health professionals have their own special goal: to transmit to their students and trainees the knowledge and skills needed for successful professional practice — fully, accurately, and without bias. To do that, two ethical principles rise to the top: to accomplish their primary goal, teachers need to have competence in the knowledge and skills being transmitted to students and integrity in dealing with the asymmetry of power that exists in every teacher-student relationship.11

Imbalance of power is responsible for the occasional abuses of research trainees that I’ve
seen in my role of ethics consultant, like when investigators take credit for the work of their graduate students and postdocs. Worse still are the scandalous results of sexual harassment that this year destroyed the career of Professor Colin McGinn at the University of Miami and last year resulted in a long prison term for Jerry Sandusky and catastrophic damage to Penn State University. But worse than both of those is a widespread stain on the culture of medical education.

In medical schools, professorial competence isn’t usually a problem, but abuse of power is. My field of surgery probably has a reputation for more mistreatment of students and residents than other fields — I’m not sure that’s true. A medical school dean of education put it this way: “It is with difficulty that I articulate the often dominant teaching culture of our profession, which is adversarial and based on intimidation, public humiliation, harassment, belittlement, and fear, especially in the clinical years. This is an international phenomenon, and one that includes not only physicians, but other professions in medicine as well.”

Data supports this bleak view. The Medical School Graduation Questionnaire, administered to all students graduating from AAMC accredited medical schools, was answered by over 12,000 graduates in 2012. The questionnaire has a section devoted to medical student mistreatment, which lists 15 abuses ranging from serious, such as public humiliation, to very serious, such as requests for exchange of sexual favors for grades. The percent of students who said they personally experienced at least one of those 15 abuses was 47.1% — nearly 6,000 of the more than 12,000 respondents. Maybe the descriptors of our teaching culture, “adversarial and based on intimidation, public humiliation, harassment, belittlement, and fear” aren’t very far off-base.

To do our job as teachers well, we have to be aware of our primary goal: transmitting our knowledge and skills. To reach that goal, our most important ethical principles are competence and integrity. It should be obvious that we have to be not only competent in our disciplines, but also have to have integrity in the way we manage the special power we hold over our students and residents, as well as other trainees.

Now I’m going to talk about ethics for the clinical professions, taking medicine as representative of all of them, while recognizing that the ethical principles that guide the professional activities of physicians are in some ways different, but in many more ways, very similar to those of other clinicians.

The foremost professional goal of physicians is to work for the good of the patient. For the healing relationship to succeed, the first requirement is that patients trust that their physicians are acting in their best interest. There’s good reason for this: successful medical care requires that physicians have access to intimate details of the patient’s personal history, as well as intimate access to the body itself ways that are allowed to no one else, including the patient’s minister, lawyer, and even the patient’s husband or wife. Think here of physical exams of private body parts and surgical opening of body cavities in patients who’re anesthetized and completely vulnerable. The fundamental need for those
extraordinary intimacies means that patients have to trust that their doctors are acting in the patient’s interest rather than the doctor’s.

So for those reasons, the virtues required for physicians to serve the good of the patient come in two packages: what’s good for the patient from the biological perspective and what’s good for the patient in terms of their own value systems. First, to serve the patient’s biological good, the physician has to have scientific objectivity and has to be competent in both medical knowledge and technical skill. Then, to serve the good of the patient from the patient’s point of view — the physician has to respect the patient’s personal values, has to be honest in disclosing the information patients need to make decisions that’re consistent with their own values, and has to have compassion for the patient’s humanity and suffering. To sum it up in a single word, the physician has to be trust-worthy — that is, has to have all of the other qualities I just mentioned to be truly worthy of the patient’s trust.

But, there’re problems in the house of medicine. When a medical error occurs and a patient is harmed, the doctor’s first responsibility is to the patient and the patient’s right to know what happened. Yet a survey of 1300 physicians found that only half of them, 50%, believed that a serious error should be disclosed to the patient. As a matter of honesty and personal character, physicians should not withhold information from patients.

To point to another problem, honesty requires that physicians shouldn’t lie to insurance companies. Yet misrepresentation of diagnoses and procedures is commonly supported by physicians. Asked if they would approve of deceiving an insurance company to get coverage of an uncovered service, such deception was supported by 58% of physicians for a coronary bypass operation, and 56% for arterial revascularization. They do this ostensibly to help patients, but these deceptions may be self-serving, since the physician and the hospital often benefit by being paid for their otherwise unpaid services.

There are no doubt practical reasons for withholding from patients information about medical errors and for lying to insurance companies. But, it can be argued, as I do, that these acts are simply wrong, they’re wrong because dishonesty diminishes personal character, and most importantly — it undermines trust-worthiness.

The ACA contains lots of penalties for violating the law. But, laws and threats of punishment are blunt instruments. They are far from the best way to address ethical misconduct. Doing the right thing depends on developing habits of doing the right actions in the given circumstances, and these habits have to be internalized for right action to be reliable in the long run. We internalize ethical behavior by doing what we know to be right deliberately every time we make a choice. These habits of chosen actions are what some have called virtues.

Albert Einstein said, in 1930, “I never think of the future. It comes soon enough.” The emerging health care system is coming soon enough, but its form is hardly predictable. We need to be prepared for whatever emerges, and fortunately, as human beings with a human nature that’s been stable for thousands of years, our responses to the coming challenges
can rely on our internalized ethics — if you will, our virtues — to meet the upcoming challenges successfully.

For administrators, this requires consistently acting with fairness and common decency in the service of the institution’s flourishing. For biomedical investigators, it requires exercising impeccable honesty and integrity in the responsible conduct of research in the service of science. For teachers, it requires competence and integrity in conveying knowledge and using power. And for clinicians, it requires being trustworthy in every way, in the service of unswerving, even ferocious dedication to the welfare of our patients. We owe them nothing less.

Thank you.
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