Conclusion

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These last words are titled "Conclusion," but they should be "Inception." Professor Jacob Needleman encourages a vigorous conversation about commercialism in medicine. An honest conversation, he maintains, will spur understanding, indignation, and reformation. We do sincerely hope that such a conversation begins and is carried on to meaningful change. However, as the essays in this collection show, that conversation must take place in many different places and about many different things. All of our authors acknowledge that the problem of commercialism is extremely complex. It cannot be understood as a simple fact or a single feature of modern healthcare. Thus, the conversation that discusses it must be varied and diverse.

Dr. Joe Fins notes, at the opening of his essay, that the discourse about the Clinton Health Plan was carried out almost exclusively in the language of health policy and economics. It was silent about clinical competence, care, compassion, and continuity, which constitute the actions of doctors caring for patients. The problem of commercialism is, indeed, a problem of health policy and economics. Professor Marc Rodwin's essay demonstrates how that conversation might go. But, as many of our authors have noted, commercialism deeply affects the essence of the physician–patient relationship. The conversation must concern that as well. And those conversations must overlap.

Our authors have also pointed out that, beyond health policy and economics and beyond the intimate confines of the patient–physician relationship, major cultural and social beliefs and practices surround the commercialization of healthcare. Dr. Larry Churchill's exposition of the hegemony of money in our culture shows how difficult it has become to attribute value to any human characteristics or events that cannot be assessed in monetary terms. Dr. Jon Moreno's treatment of the primacy of autonomy reveals that an unintended consequence of bioethicists' endorsement of autonomy as the liberation of patients from medical paternalism has been the opening of a choice-filled market of healthcare. Dr. Larry Schneiderman depicts how media, advertising, and journalism can invade that market. Conversations about the hegemony of money and about the primacy of autonomy take place only on the fringes of these broad and pervasive cultural beliefs that are not easily shaken by critical words.

All of our authors note, some with anger and others with dismay and regret, the demise or the dimming of "professionalism." Ironically, this word connotes for many the power of elite practitioners to dominate the conditions of the

Cambridge Quarterly of Healthcare Ethics (2007), **16**, 439–442. Printed in the USA.
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DOI: 10.1017/S0963180107070557

https://doi.org/10.1017/S0963180107070557 Published online by Cambridge University Press

market in which they work; it is the essence of self-interest. At the same time, it also conveys the exact opposite, the altruism that puts the interests of one's patients or clients ahead of one's own. It is this latter meaning, the highest ethical value of practitioners, that our authors see dimming or dying in the culture of commercialism. Several of our authors propose that when this commitment to altruism is lost, the most essential feature of healing, namely, trust between doctor and patient, will also disappear. As a value, it lives primarily in the conscience of practitioners. The conversation about commercialism is ultimately a conversation about conscience.

The first conversation about conscience is an intimate, interior conversation, carried on by a person who wonders about the right way to act. This interior conversation recognizes duties and realizes that duties may conflict; the conversation weighs the pros and cons of acting when duties conflict and also assesses how personal interest may draw away from duty. This interior conversation is a lonely one. Yet the duties and the interests that are weighed are creations of the culture in which the conscientious person lives. Thus, the interior conversation must engage a broader public conversation about that culture and its institutions.

It seems apparent that the interior conversation about commercialism is one that every professional must undertake. There is little in our culture to encourage that sort of "soul-searching." Thus, the groups of professionals must encourage and support the conversation. Some professional organizations, such as the American College of Physicians, have realized that this is a crucial function. They must inspire and instruct the personal interior conversation by a continuous stream of opinion and facts that show the dangers of allowing medical practice to be swallowed up in commerce.

The interior conversation of conscience is not only a lonely one: It is a vulnerable one that can be extinguished by many other concerns. The practical concerns of making a living, becoming successful or prominent, of building a practice, of staying current in science can overwhelm the "small voice" of conscience. Again, support must come from the organizations and associations in which professionals participate. Because these organizations are often centered on self-interest, they must undergo something of a conversion to support the conversation about the dangers of commercialism.

However, conscience is not simply the recognition of right ways as distinct from wrong ways of acting. It is, almost always, the realization of perplexity: The right way is not clearly distinct from the wrong way. The contemporary debates about "conflict of interest" that are heard in politics and business, as well as in science and medicine, reflect that perplexity. Several of our authors, in particular Dr. Kassirer, stress the problem of conflict of interest in contemporary healthcare. The powerful influence of pharmaceutical companies on doctor's prescribing, on hospital purchasing, and on government policy is the most prominent example. A conflict of interest is not, in itself, immoral: It simply means that a person can be influenced by diverse incentives, not that they are so influenced. It is up to that person's conscience to assure that the incentives do not lead in the wrong direction, which, in medicine, leads away from the welfare of individual patients. However, any honest discussion of conflict of interest goes much further: It recognizes some incentives have greater power than others, particularly when those incentives are colored by

https://doi.org/10.1017/S0963180107070557 Published online by Cambridge University Press

strong cultural beliefs, such as the hegemony of money. Mere disclosure that one has diverse interests may not be sufficient; rather the outright repudiation, by law or by policy, of some set of incentives may be the only safe course. The recent prohibition on all gifts from drug companies to doctors by several major medical schools illustrates this safe course.

Yet, again, even the rejection of some temptation leaves conscientious practitioners vulnerable. They must practice within a system that is itself structured in favor of those incentives or, at least, deeply marked by them. A conscientious practitioner practices in a competitive setting. A competitive setting requires attitudes and practices that mimic the business environment. Practitioners, or groups of professionals, who do not adopt the ways and means of that environment will lose out. Any professional who sincerely adheres to the altruism of ideal professionalism will have to be isolated from the economic environment surrounding them. Of course, some isolated individuals will survive and even thrive; their very uniqueness may attract a following. Other isolated individuals may form a coterie of like-minded colleagues. *Les Medicins san Frontiers* is one example of doctors dedicated to care of the impoverished and destitute, manifesting altruism to a high degree and practicing medicine outside the confines of traditional delivery systems. Others, less austere in their altruism, may attempt forms of practice designed to remove them from the financial influences in medicine.

Most physicians, however, will continue to work in the competitive marketplace. Their practice will be entangled in the financial systems constructed by third-party payers, hospital systems designed for efficiency, research projects aimed at immediate productivity, and government regulation obsessed by uniformity. They will constantly feel the conflict of interest that pulls them away from responsibility for patients and toward personal profit. Even a call to conscientious professionalism may be difficult to hear within this culture. The conversation about money and medicine that we encourage can be easily drowned out.

For these practitioners, isolation is impractical and impossible. For them, professionalism has a real role, if they choose to accept it. Initially, professionalism can be seen as a mantle, shielding clinicians from outside influence. It does not isolate the practitioner but rather can insulate the "interior conversation of conscience" and protect it from undue influence. We speak of insulation by remote analogy to electrical insulation: The flow of conscientious altruism that activates the relation between patient and physician must be concentrated and directed through the organization and financing of healthcare in the way electrical current is protected from dissipation by insulating materials. What payment reforms, changes in healthcare access, restrictions on gifts to doctors by drug companies are needed to provide some insulation? What kinds of information, education, and advertising should be offered to insulate the conscientious professional from the power of commerce and yet enable him or her to utilize the benefits of commerce for the welfare of patient?

Professionalism can be seen in a more active way, as an attitude, not just a shield. That attitude is grounded in altruism and empowered by it. The American College of Physicians' Project in Professionalism that establishes moral guideposts for the profession is an important effort to articulate that attitude. The task before us is not only to describe the nature of insulation that

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can shield healthcare professionals from the harms of commercialism, but to recognize the values and virtues that an attitude of professionalism should express and embody. We hope that the ideas and the challenges presented by the authors of the papers in this Symposium on Commercialism in Medicine will stimulate an ongoing exploration by the professions, the healthcare community, and the society. So, our symposium ends and, we hope, the conversation begins.

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