Debating Conflicts: Medicine, Commerce, and Contrasting Ethical Orders

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I. INTRODUCTION

Every important social debate is grounded in a seminal development in the history of ideas, and can be understood in proportion as the relevant development is understood. The debate of concern to this Article—that involving the appropriate relationship between physicians and the pharmaceutical industry—is grounded in the development known to historians as the shift in modern Western culture from status to contract.¹

Part II of this Article introduces that shift through reference to the transformation of the family in the last decades of the twentieth century. It then describes the consequences of the shift within the world of health care. It briefly reviews the social history of medicine since the middle of the twentieth century and describes that history in light of the shift from status to contract. Then Part III focuses on one aspect of the broad shift by examining contrasting understandings among physicians of the parameters of medicine. In particular, Part III compares an ethical order that continues to reflect traditional patterns in directing physicians’ conduct with an ethical order firmly committed to the values of the marketplace. Physicians’ contrasting attitudes toward links with industry, and more specifically, toward rules of disclosure as a potential antidote to bias, are illustrative. Finally, in conclusion, the Article

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¹ See HENRY MAINE, ANCIENT LAW 98-100 (J.M. Dent & Sons 1977) (1861).
suggests that the depth of the ideological divide among physicians, apparent in discourse about links with industry and, more generally, in discourse about the profession’s self-identity and scope, may augur a dramatic division of the medical profession into two essentially distinct professional groups.  

II. FROM STATUS TO CONTRACT: THE CONCRETIZATION OF AN IDEA

The terms central to an understanding of the shift from status to contract were defined over a century ago by the British social theorist, Sir Henry Maine. Maine’s vision of a social world defined through relationships of “status” posits a system of values grounded in the nature of things; in that world, the values are seen as immutable and as providing the only acceptable guide to social relationships. In sharp contrast, Maine’s notion of “contract” reflects the conviction that all systems of value are grounded in the preferences of particular individuals, and should therefore be shaped and reshaped following individual choice.

Maine’s understanding of status further describes a social universe that insists that traditional institutions be preserved, in significant part by insisting that individuals subordinate their needs and desires to the needs and desires of traditional communities, and thus as a matter of principle, restrict individual autonomy. Contract insists, as a matter of principle, that the needs and desires of the autonomous individual be the primary arbiter of social institutions. It further insists that those needs and desires be established and re-established to reflect the perceived

2. By “ideology” and “ideological” this Article refers to a set of basic forms through which people understand their world and act in that world. The term is not used here to refer to a system of false or political beliefs. The use of ideology reflects that of the French anthropologist, Louis Dumont. Dumont wrote:

   Our definition of ideology thus rests on a distinction that is not a distinction of matter but one of point of view. We do not take as ideological what is left out when everything true, rational, or scientific has been preempted. We take everything that is socially thought, believed, acted upon, on the assumption that it is a living whole, the interrelatedness and interdependence of whose parts would be blocked out by the a priori introduction of our current dichotomies.


3. See infra Part III.C.1.c.

4. See infra notes 9-10 and accompanying text.

5. See infra notes 7-10 and accompanying text.

6. MAINE, supra note 1, at 98-100.

7. See id.
imperatives of autonomy—and that the rules governing their shifting configurations be those that govern transactions in the marketplace. 8

In particular, Maine distinguished between those aspects of social life defined through “family dependency” (and grounded in relations of status) from those defined through “individual obligation” (contract). 9 In Maine’s view these domains of social life were not in balance. Rather over time, the domain of contract had increasingly been encompassing that of status.

The Individual is steadily substituted for the Family, as the unit of which civil laws take account. The advance has been accomplished by varying rates of celerity . . . . But whatever its pace, the change has not been subject to reaction or recoil . . . . Nor is it difficult to see what is the tie between man and man which replaces by degrees those forms of reciprocity in rights and duties which have their origin in the Family. It is Contract.

. . . All the forms of Status taken notice of in the Law of Persons were derived from, and to some extent are still coloured by, the powers and privileges anciently residing in the Family. If then we employ Status, agreeably with the usage of the best writers, to signify these personal conditions only, and avoid applying the term to such conditions as are the immediate or remote result of agreement, we may see that the movement of the progressive societies has hitherto been a movement from Status to Contract. 10

Maine’s depiction is more useful in suggesting ideological perspectives than it is useful as history. 11 During most of the nineteenth and twentieth centuries, for instance, everyday life in the United States was viewed in terms of contrasting social domains, viewed respectively through the parameters of “contract” and through the parameters of “status.” The contrast between home and marketplace (between family and work), for example, clearly reflected the distinction between status and contract. 12

8. See id. at 99-100.
9. Id. at 98-100.
10. Id. at 99-100.
12. See infra notes 14-23 and accompanying text.
A. The Paradigmatic Case: The Transformation of the Family

That contrast was especially central to Americans’ views of everyday life in the middle decades of the twentieth century. David Schneider’s anthropological study of American kinship, carried out during the middle of the century, revealed the cultural salience of the distinction between status and contract to understandings of and expectations about family relationships. Schneider captured the socio-cultural parameters of the family in the United States just before it began dramatically to merge (as an ideological matter) with the world of work:

The set of features which distinguishes home and work is one expression of the general paradigm for how kinship relations should be conducted and to what end. These features form a closely interconnected cluster.

The contrast between love and money in American culture summarizes this cluster of distinctive features. Money is material, it is power, it is impersonal and unqualified by considerations of sentiment or morality. Relations of work, centering on money, are of a temporary, transitory sort. They are contingent, depending entirely on the specific goal—money.

...[T]he opposition between money and love is not simply that money is material and love is not. Money is material, but love is spiritual. The spiritual quality of love is closely linked with the fact that in love it is personal considerations which are the crucial ones. Personal considerations are a question of who it is, not of how well they perform their task or how efficient they are. Love is a relationship between persons.

Schneider summarized the family in American culture as a social unit of “enduring, diffuse solidarity.” Generally, he explained, “[t]he end to which family relations are conducted is the well-being of the family as a whole and of each of its members.” More particularly, the American family circa mid-twentieth century reflected solidarity in that relationships within the unit were (or were expected to be) “supportive, helpful, and cooperative”; describing family relationships as “diffuse” referred to the absence of a narrow “specific goal or... specific kind of

14. Id. at 48-49.
15. Id. at 50, 52 (emphasis omitted).
16. Id. at 50.
behavior,” and finally, family relationships were expected to “endure”—family cooperation had no “specific goal or . . . specific limited time in mind.”

Moreover, so-called traditional family relationships were grounded in a set of presumed statuses, defined largely through reference to age and gender. Roles followed statuses. Hierarchy was assumed and prized.

In contrast, the world of the marketplace (the world of “work”) has long prized the putatively equal autonomous individual. Whereas people defined themselves in the traditional home through reference to love, community, and enduring connection, people defined themselves, and continue to define themselves in the marketplace through reference to money, negotiated choice, and relationships forged in bargains and not expected to last beyond the terms of the bargains that effected them.

The transformation of family patterns in the last decades of the twentieth century occurred with stunning speed. Although the roots of change had long been growing, public displacement of modes of family relationships deemed close to sacred with modes of relationship familiar to actors in the marketplace was accomplished as a practical matter within a couple of decades. By the last years of the twentieth century, American law defined adults within families as more like business partners than like their family counterparts in an earlier time.

17. Id. at 52.
18. The term “traditional” is used here to describe the patterns of relationships common to the American family between the start of the Industrial Revolution and the last decades of the twentieth century. Essentially, it is the family that Schneider analyzed in American Kinship. See id. at 12-14.
19. See, e.g., Milton C. Regan, Jr., Family Law and the Pursuit of Intimacy 6, 9-10 (1993) (noting that nineteenth-century families were predicated on assumptions about gender differences, and noting that nineteenth-century family law assumed that family members would “act in accordance with certain standard expectations that flowed from their statuses as husbands, wives, fathers, and mothers”).
20. Id. at 9-10.
21. See John Demos, Past, Present, and Personal: The Family and the Life Course in American History 31 (1986) (distinguishing the world of home from the contrasting world of work, and describing the home as a refuge against the outside world).
22. Even in the nineteenth century, the seeds of later change were planted. The appearance of the Married Women’s Property Acts, providing married women with legal authority to control at least some of their property, re-shaped relationships between husbands and wives. See, e.g., Lawrence M. Friedman, A History of American Law 209-11 (2d ed. 1985) (summarizing Married Women’s Property Acts).
23. Specific relevant changes include: the promulgation of no-fault divorce laws in the second half of the twentieth century, see Doris Jonas Freed, Grounds for Divorce in the American Jurisdictions (as of June 1, 1974), 8 Fam. L.Q. 401, 402-21 chart A (delineating divorce grounds in the states in 1974); the acceptance of prenuptial agreements, see, e.g., Posner v. Posner, 233 So. 2d 381, 383, 384 (Fla. 1970) (noting that such agreements in contemplation of divorce were previously
B. Shifts in the World of Health Care: The Physician-Patient Relationship

A similar transformation has occurred in the world of health care during the last century. This section traces that transformation of relationships within the world of health care from relationships grounded in status to relationships grounded in contract. It first characterizes health care, especially the physician-patient relationship, between the last decades of the nineteenth century and the last decades of the twentieth century. It briefly describes the commercialization of health care in the second half of the twentieth century. It then depicts some of the essential socio-cultural changes that have redesigned the scope of medicine in the last several decades.

1. The World of Health Care Before Widespread Commercialization

In the United States, the professionalization of medicine occurred in the decades following the Civil War. By the end of the nineteenth century, physicians began to see themselves as responsible for a body of organized knowledge that could be taught and used for public benefit. By the early decades of the twentieth century, the American Medical Association was functioning as a guild, focusing on the well-being of its members. The development of a standardized curriculum for medical training, and the increasing respect Americans showed for professional

seen to violate public policy and taking judicial notice of increase in rate of divorce); and that by the start of the twenty-first century at least one state provided for marriage between people of the same gender, see Goodridge v. Dep't of Pub. Health, 798 N.E.2d 941 (Mass. 2003) (holding the ban on same-gender marriage unconstitutional).

24. Before the middle of the nineteenth century, medicine was largely unregulated. Physicians, for instance, were not licensed. It was possible to train in a variety of schools, each associated with a particular philosophy of medicine. John Pickstone, Medicine, Society, and the State, in THE CAMBRIDGE HISTORY OF MEDICINE 260, 261 (Roy Porter ed., 2006) [hereinafter CAMBRIDGE HISTORY OF MEDICINE]. This Article begins its story after this period because it is not expressly concerned with providing a history of the practice of medicine in the United States, but with suggesting some consequences for those engaged in the world of health care of the transformation of medicine from a cottage industry to big business. Id. at 260-61.

25. This section is indebted generally to Paul Starr's history of American medicine. See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).


27. Id.


29. STARR, supra note 25, at 112-16.
authority generally, bolstered the development of medicine as a profession with high status.\textsuperscript{30}

By the early twentieth century, doctors' incomes increased significantly.\textsuperscript{31} Furthermore, physicians steadfastly opposed any changes that would have increased the power of government or private corporations over the profession.\textsuperscript{32} Doctors operated to safeguard professional autonomy and wages. And at least until the end of the twentieth century, the legal system did not interfere with that agenda.\textsuperscript{33} Sometimes it supported it actively.\textsuperscript{34}

As a result, physicians in the United States continued to gain social influence and significant financial rewards.\textsuperscript{35} Medical authority was both assumed and venerated.\textsuperscript{36} Yet, while doctors enjoyed prestige and economic success,\textsuperscript{37} medicine remained a cottage industry,\textsuperscript{38} largely free from the involvement of government or corporate rule. The profession thus enjoyed extraordinary autonomy.\textsuperscript{39} The privileged social position of physicians in the United States encouraged and justified the development of a hierarchical form of relationship between physician and patient.\textsuperscript{40} Thus, during the first three-quarters of the twentieth

\textsuperscript{30} Id. at 17-29. Starr notes that physicians have not always enjoyed high status and high income. Even in the contemporary world, some societies have viewed physicians less felicitously than others. During the years of the Soviet Union, doctors earned less than seventy-five percent of the average industrial wage earner. Id. at 6.

\textsuperscript{31} Id. at 143.

\textsuperscript{32} Id. at 200.

\textsuperscript{33} The profession was able to ward off government interest in providing health services for the citizenry (at least until the 1960s). Roosevelt had been interested in including health care as part of the social security legislation of the 1930s. The strong response of physician professional groups dissuaded him. Id. at 266-79.

\textsuperscript{34} For instance, the corporate practice of medicine doctrine prohibited the employment of doctors (to practice medicine) by corporations. Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 509 (1988).

\textsuperscript{35} STARR, supra note 25, at 4-5.

\textsuperscript{36} Id. at 337.

\textsuperscript{37} Id. at 5.


\textsuperscript{39} STARR, supra note 25, at 6.

\textsuperscript{40} See id. at 81. Starr quotes a nineteenth century Hungarian doctor who, arriving in the United States in the 1870s, expressed surprise at the comparative absence of social distance between physicians and patients in the United States. Id. at 80-81.

Changes in the economics of medicine by the end of the nineteenth century augmented the profession's burgeoning prestige. Hospitals were developing from sad holding stations for poor, sick people into the centerpiece of the medical enterprise. Roy Porter, Hospitals and Surgery, in CAMBRIDGE HISTORY OF MEDICINE, supra note 24, at 176, 209-10. The expense of hospitals in the
century, physicians enjoyed autonomy within a hierarchical system, justified by physician expertise and by the expectation that physicians would focus on patient welfare. Patients in turn were expected to trust, rely on, and remain loyal to their physicians. 41

That the medical profession prized its unique status and that it remained separate, in fact, from the world of the corporate marketplace until the last decades of the twentieth century were essential to the profession’s own developing sense of identity. In particular, medicine’s perceived separation from the marketplace encouraged forms of interaction among professionals and between professionals and patients that resembled interactions in families, churches, and schools rather than interactions in the marketplace. 42 Surely, the portrait of the physician as compassionate healer and trusted expert rested on wistful romance as well as fact. 43 Yet, that image reflected society’s hopes and expectations. Moreover, in fact, doctors made house calls, developed long-lasting relationships with patients, and touched them in the course of clinical care. 44 All of this reinforced a view of physicians as kindly, trusted care givers. In short, social patterns defining the doctor’s role as well as society’s vision of the doctor-patient relationship reflected the values of the home far more than the values of the marketplace.

2. The Commercialization of Medicine

That universe survived, without effective challenge, until the last decades of the twentieth century, though inklings of change appeared soon after World War II. In particular, the development of biomedical technology, laboratory tests, and innovative pharmacological options for United States was carried by charities, by paying patients, and later by health care insurers and those who paid for that insurance. Id. at 209; Pickstone, supra note 24, at 282, 287.

The model for American health insurance for most of the twentieth century emerged at Baylor University Hospital in Texas in 1929. The hospital began to promise specified levels of care to groups of subscribers (such as teachers) who paid periodic premiums to the hospital. RICHMOND & FEIN, supra note 28, at 30-31. By the 1940s, the United States had effectively committed itself to a voluntary insurance system funded by employers. Id. at 36-39.


42. See SOMERS & SOMERS, supra note 41, at 458.

43. Id. at 457 (calling the “popular conception of the doctor-patient relationship... a mixture of fact and fancy”).

44. See LEWIS THOMAS, THE YOUNGEST SCIENCE: NOTES OF A MEDICINE-WATCHER 55-58 (1983) (observing that ill people need to be touched, and that now, sophisticated diagnostic testing allows physicians to treat patients from afar).
treat a wide set of diseases and physical ills augmented the status, but altered the character of the physician-patient relationship.\textsuperscript{45}

Slowly at first and then with increasing certainty, physicians began to focus less on the patient-as-person and more on innovative therapeutic procedures and treatments.\textsuperscript{46} This shift occurred cotermously with a set of startling financial and structural shifts in the world of health care. These developments included, in particular, significant public financing for health care with the passage of Medicare and Medicaid in the 1960s, the purchase of hospitals and nursing homes by corporate chains, and precipitous increases in the cost of health care that resulted in employers replacing indemnity insurance with "managed-care" plans.\textsuperscript{47} Each of these fed the others.\textsuperscript{48} Through the 1970s, this developing medical-industrial complex\textsuperscript{49} grew alongside the world of independent practicing doctors.\textsuperscript{50}

In sum, by the 1970s and early 1980s, the groundwork was being laid for a broad commercialization of medicine.\textsuperscript{51} By the middle of the 1980s, Wall Street investment houses were establishing health care

\begin{itemize}
  \item Edward Shorter, \textit{Primary Care}, in \textit{Cambridge History of Medicine}, supra note 24, at 103, 134-35.
  \item \textit{Id.} at 134. Shorter explained:

  The whole patient-as-a-person movement fell into desuetude after 1950, replaced by a new generation of physicians filled with an overweening therapeutic self-confidence. The aspects of the doctor-patient relationship to which patients had once thrilled, such as the physician's show of interest in the history-taking or the laying on of hands in the physical exam, became down-played in favour of using the resources of diagnostic imaging and of laboratory tests in the diagnosis of disease.

  \textit{Id.}
  \item So, for instance, as managed care grew, investors became increasingly interested in putting money into health maintenance organizations, as well as hospitals and nursing homes. \textit{Starr, supra} note 25, at 428 (describing the corporate transformation of medicine).
  \item The term "medical industrial complex" seems first to have been used by Arnold Relman in the 1980s. His use of the term was a play on President Eisenhower's notion of a "military-industrial complex." \textit{Relman, supra} note 47, at 24.
  \item \textit{Starr, supra} note 25, at 428-29. Starr describes the emerging medical-industrial complex of the 1970s as having involved:

  [T]he linkages between the doctors, hospitals, and medical schools and the health insurance companies, drug manufacturers, medical equipment suppliers, and other profit-making firms. Their interests seemed so closely interlocked that they constituted a single system, a seamless web of influence, a common front for a particular style, structure, and distribution of medical care.

  \textit{Id.}
\end{itemize}
groups. That development was supported by the Reagan administration’s focus on market forces in responding to the increasing cost of health care for the government, in particular, and for society, generally. Even more, the high cost of health care was framed by reference to the growing portion of the U.S. population, especially people without insurance, who could afford little or no health care.

By the end of the twentieth century, the process of commercializing medicine intensified, fostering a clear shift in the parameters of the physician’s task and in the scope of the physician-patient relationship. These changes have reshaped the scope and redefined the meaning of the relationship between physicians and patients; they have undermined the communal dimensions of relationships among all participants in the world of health care; and they have altered physicians’ assumptions about their work and its value. They have shaken physicians’ sense of professional identity, and more seriously, have created discontent and confusion among physicians and among patients and potential patients.

3. The Socio-Cultural Parameters of Change in the World of Health Care: From “Status” to “Contract”

A set of additional factors did not so much cause, as they facilitated, the transformation of medicine at the end of the twentieth century. The broad ideological shift from a society that had long viewed itself as composed of separate social domains—those defined in terms of status and those defined in terms of contract—began to reshape the world of health care and medicine. Slowly, the presumptions that undergirded the world of the marketplace began routinely to shape relationships in those social domains once shaped through presumptions that contrasted with those operative in the marketplace. That widespread social shift was essential to the particular transformation of medicine from a profession grounded in hierarchically structured relations of trust, dependence, and loyalty to one defined in marketplace terms.

52. Id. at 76-78.
53. Id. at 88.
54. STARR, supra note 25, at 381-82.
55. See id. at 428 (noting that by the early 1980s the medical profession was “in the early stages of a major transformation”).
56. See, e.g., Peter A. Ubel, Commentary, How Did We Get into This Mess, in CONFLICTS OF INTEREST: CHALLENGES AND SOLUTIONS IN BUSINESS, LAW, MEDICINE, AND PUBLIC POLICY 142, 143-49 (Don A. Moore et al. eds., 2005) [hereinafter CONFLICTS OF INTEREST] (discussing possible reasons for the pharmaceutical industry’s influence over physicians).
57. See supra notes 21-23 and accompanying text.
Although the transformation of medicine in the last decades of the twentieth century resembles the transformation of families, medicine, unlike families, was always connected openly to the world of commerce.\textsuperscript{58} Medicine, however, was unusual among the professions, in that society viewed medicine as a domain that valued, and even depended upon, many of the social forms that characterized the nineteenth- and early twentieth-century family. Doctors, for instance, expected patients to respect their conclusions, to follow their advice, and to remain loyal.\textsuperscript{59} Patients rarely disagreed with that vision of the physician-patient relationship. Before the last few decades of the twentieth century, neither doctor nor patient viewed patients as equal partners in the healing relationships; patients had no particular right to, and were not necessarily considered well served by, knowing, the details of their illnesses or treatment options.\textsuperscript{60}

That physicians until quite recently, almost uniquely among the professions, defined themselves in opposition to large commercial and bureaucratic interests, provided support for doctors’ participation in a universe that defined the physician-patient relationship through the terms of status rather than those of contract.\textsuperscript{61} Arnold Relman, a former editor-

\textsuperscript{58} Families have a myriad of financial dimensions also. However, since the industrial revolution, families have been viewed in contrast to the world of work. Thus, the claims here are about cultural perspectives and ideology more than they are about the actual relevance of commerce to any set of social relationships. \textit{See supra} note 2 (defining ideology as used here).

\textsuperscript{59} \textit{See} Dolgin, \textit{supra} note 41, at 140 & n.15; SOMERS & SOMERS, \textit{supra} note 41, at 459-60.

\textsuperscript{60} The term “informed consent” (regarding a patient’s right to information about diagnosis and care) may have first been used by a court in Salgo v. Leland Stanford Jr. Univ., 317 P.2d 170, 181 (Cal. Ct. App. 1957). \textit{Salgo} represents a transitional decision. On the one hand, the court explained that a “physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.” \textit{Id.} On the other hand, the court noted the doctor’s “discretion” not to reveal information “consistent, of course, with the full disclosure of facts necessary to an informed consent.” \textit{Id.}


\textsuperscript{61} \textit{See} STARR, \textit{supra} note 25, at 25. Paul Starr explains:

[I]n the late nineteenth and early twentieth centuries, doctors were able to reverse the history that other occupations experienced. While many skilled crafts were losing monopoly power, the physicians were establishing theirs. In the same period as the crafts were being subordinated to large corporations, the medical profession was institutionalizing its autonomy. The doctors escaped becoming victims of capitalism and became small capitalists instead.

\textit{Id.}
in-chief of the New England Journal of Medicine, described health care in the United States in the early 1960s:

[At that time] medical care in the United States consisted mostly of personal transactions between physicians and patients, which took place in patients' homes, doctors' offices, or not-for-profit hospitals and clinics. Only a few of these transactions involved expensive technology or highly specialized facilities, and primary-care physicians could spend the necessary time with their patients.62

At least in part, that system served physicians and, to a significant extent, it served many patients. Doctors were paid respect, often virtually homage, not only by patients, but by the social worlds in which they lived. They felt special; their work was deemed highly meaningful, their expertise was prized,63 they were paid well, they enjoyed professional autonomy,64 and they were appreciated and trusted by patients.65 Patients, in their turn, benefited from the comfort provided by their trust in and loyalty to their doctors. That was not only satisfying per se; it could promote healing.66

The collapse of that universe was a product of a variety of economic and political forces. In addition, it was facilitated by the general abandonment of "traditional" values in those domains of social life that had been defined in contrast to the marketplace. By the last decades of the twentieth century, medicine was being shaped by managed care and by increased government regulation. Commenting on the corporatization of medicine in the second half of the twentieth century, Paul Starr wrote:

Although physicians and voluntary hospitals have been preoccupied with government regulation, they may be on their way to losing their

62. Relman, supra note 47, at 23.
63. See Kenneth Kipnis, Ethical Conflict in Correctional Health Services, in CONFLICT OF INTEREST IN THE PROFESSIONS 302, 306 (Michael Davis & Andrew Stark eds., 2001) [hereinafter CONFLICT IN THE PROFESSIONS] (noting that health care professionals' "distinctive knowledge" justifies that societies license them and grant them "exclusive responsibility to deliver their distinctive services to the community").
64. BARLETT & STEELE, supra note 51, at 163 (noting that decisions about patient care, once left to physicians alone, are now determined by cost considerations voiced by third-party payers).
65. Cf. Ubel, supra note 56, at 147-48, 150 (speculating that physicians may be "interacting with industry" because industry makes them "feel special" in a world in which their income is shrinking or appears to be threatened by managed care companies and other third-party payers and they are beset with a variety of unfamiliar pressures).
66. Kipnis, supra note 63, at 306 (noting generally and with specific reference to patients in correctional facilities that patients' trust in health care professionals "is an indispensable element of the 'therapeutic alliance'").
autonomy to another master. Medical care in America now appears to be in the early stages of a major transformation in its institutional structure, comparable to the rise of professional sovereignty at the opening of the twentieth century. Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates.67

As industry has more fully encompassed and reshaped the world of medicine, medicine has begun to lose its status as an independent profession.68 The consequences have been momentous for physicians and patients. And the journey has been uncomfortable for both groups.69

III. DEBATING ACROSS AN IDEOLOGICAL DIVIDE: MEDICINE AND CONFLICTS OF INTEREST

This Part of the Article traces the socio-cultural implications of the transformation occurring within the world of health care by analyzing contrasting views about links between medicine and industry,70 as well as different understandings of how best to respond to such links. Inevitably, this discussion implicates a far broader consideration of medicine's identity and scope.

Debate among physicians about the parameters of medicine is now occurring across an ideological divide. That divide reflects the more general ideological divide in American culture regarding the expansion of autonomous individuality to domains of life once grounded in status.71

69. See, e.g., Amy L. Cralam, The Serpent in the Garden of Eden: A Look at the Impact of Physician Financial Incentive Programs and a Reconsideration of Herdrich v. Pegram, 16 J.L. & HEALTH 289 (2001-2002). Cralam notes the use of financial incentives by HMOs to "reduce the amount of care subject to insurance reimbursement" and the resultant costs to the patient. Id. at 291 (citing Tracy E. Miller & William M. Sage, Disclosing Physician Financial Incentives, 281 JAMA 1424 (1999)). "[M]any of the methods of cost-containment commonly used are found to be ethically objectionable by physicians themselves." Id. at 291-92 (citing Daniel P. Sulmasy et al., Physicians' Ethical Beliefs About Cost-Control Arrangements, 160 ARCHIVES INTERNAL MED. 649 (2000)). That conclusion was based on a survey of 1549 physicians, queried about their satisfaction with their work. Id. at 292 n.11.
70. This Article focuses on links between physicians and industry, but much of what it reports also applies to links between non-physician biomedical researchers and industry.
71. See supra notes 18-23 and accompanying text.
A. Contrasting Visions of Professional Identity

Categorized as a "profession," medicine in the United States has long been connected openly to commerce, but it was also viewed by physicians and by society as a domain that prized, and even depended upon, many of the status-based assumptions about personhood and about relationships that characterized the nineteenth- and early twentieth-century family rather than those deemed appropriate to the marketplace. 72

1. Old Options and New Ones

As those assumptions have been challenged within U.S. society generally, they have been challenged as well within the world of medicine. At present, medicine is a world in transition. Physicians disagree among themselves, in a way they did not throughout most of the twentieth century, about their professional identity and about the scope of medicine. In consequence, some physicians are confused by the pressures that inevitably attend transition; some are discontented; and some have joined forces with the marketplace and have, in effect, begun to redefine medicine from within. 73

Among other things, doctors have become disgruntled with shifts in the character of the doctor-patient relationship and with new financial pressures. Peter Ubel, himself a physician, has attempted to "look[] in physicians' heads" 74 as the character of their profession changes—as old assumptions about medical practice are challenged by a new reality. In Ubel’s view, physicians are forging links with industry because industry does what medicine once did for them but often no longer does: It makes them feel good about themselves. 75 Ubel suggests, among other things, that industry makes physicians feel more satisfied with themselves and their work than does the practice of medicine absent links to industry. 76

72. See supra notes 58-61 and accompanying text.
73. See Ubel, supra note 56, at 149 (discussing prevalence of relationship between physicians and pharmaceutical industry).
74. Id. at 150.
75. See id. at 148.
76. Id. In particular, Ubel focuses on academic physicians, but much of what he describes applies as well to practicing doctors. Ubel wrote: "[I]ndustry simply knows how to make beleaguered academic physicians feel special again." Id.

Ubel also notes the effect on doctors of falling incomes. Practicing doctors, he asserts, have faced falling incomes as a result of restrictions imposed by managed care companies and other third party payers. See id. Academic doctors have been pressured to “find ways to pay for every minute of their time.” Id. In that context, the lure presented by industry has often been compelling:
Ubel here implicitly suggests a peculiar comparison between physicians’ satisfaction in the world of community (home and medicine) three or more decades ago and their satisfaction now in the world of the marketplace. Doctors were contented with the satisfactions offered—especially to those at the top of the social hierarchy—by a world defined through the metaphors of home, rather than those of the marketplace. But once deprived of traditional professional satisfactions, some of them have begun to yearn for the revivification of traditional modes of practicing medicine. Some have switched frames of reference and begun to define themselves as full participants in the world of the marketplace—a world that the profession once openly and consistently rejected. And still others remain confused.

2. Physicians Face New Forms of Conflicting Interests

Even when medicine was a cottage industry, physicians faced conflicts of interest. However, the conflicts they face today are significantly different than those they faced a half century ago. The most pervasive conflict of interest that faced practicing physicians within the world of traditional medicine was part and parcel of the doctoring role: Doctors were paid when they provided treatment; the more treatment they provided, the more they were paid. That conflict of interest developed from within the physician-patient relationship.

Industry can be a source of relatively easy money for physicians. Industry pays physicians well to enroll patients into clinical trials—more than covering the cost of enrolling the patients. Industry funds grants with much less rigorous peer review and much faster turnaround time than federal funding agencies.

Id.

77. Arnold Relman, a former editor-in-chief of the New England Journal of Medicine, suggested in the mid-1980s that “[t]here can be no really satisfactory solution [to the problems besetting the American health care system] until the medical profession itself faces up to the threat of entrepreneurialism and decides to take a firm stand in defense of professional ethics.” Arnold S. Relman, Editorial, Dealing with Conflicts of Interest, 313 New Eng. J. Med. 749, 750 (1985).

78. See Ubel, supra note 56, 142, 148-50; see also Timothy J. Mullaney, Special Report, This Man Wants to Heal Health Care, Bus. Wk., Oct. 31, 2005, at 74, 75. Mullaney’s piece describes the efforts of Dr. David J. Brailer to revamp American health care on the model of United States manufacturing. In particular, Dr. Brailer proposes providing each person in the United States with an electronic record of his or her health care history and then linking all of the records into what he calls the National Health Information Network Inc. Mullaney explains that Dr. Brailer “believes in . . . an even more capitalistic version of American medicine than today’s system.” Mullaney, supra, at 77.


80. See Andrew Stark, Why Are (Some) Conflicts of Interest in Medicine So Uniquely Vexing?, in CONFLICTS OF INTEREST, supra note 56, at 152, 154. Stark quotes Arnold Relman who concluded that “‘professional ambition in medical scientists, whatever its danger, has a redeeming

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also encountered financial conflicts that were not inherent to the doctoring task, such as “fee-splitting” arrangements. The practice was endemic to American medicine since the last decades of the nineteenth century. Although it was condemned by the American Medical Association, professional countermeasures were routinely lax. Even more troubling, the profession viewed the practice as comparatively benign when compared with “serious” ethical violations such as “stealing” a colleague’s patients.

Both fee-splitting and “stealing” other doctors’ patients, however unpleasant and unethical, differ from financial conflicts of interest created by collaboration with industry mostly in that they challenged the morality of the profession but not the socio-cultural parameters that fashioned its essential identity. By focusing on physicians’ contemporary responses—both public and professional—to the debate about forging financial links with industry, the next section considers this difference in more detail.

B. New Conflicts of Interest—Links with Industry

In the last several decades, many academic physicians and practicing doctors have accepted gifts and have entered into other financially valuable relationships with industry. Yet the number of those willing openly to criticize those links far outweighs the number

social value absent from the pursuit of private external interests.” Id. (quoting Arnold S. Relman, Editorial, Economic Incentives in Clinical Investigation, 320 NEW ENG. J. MED. 933, 934 (1989)).

81. Clearly, the conflict described is “inherent” to the doctoring task only because health care was paid for through fees for service. Other arrangements exist and create other sorts of conflicts.


83. Id. at 709.

84. Id. at 704 (noting that “the AMA first ignored fee splitting . . . , then denounced [it], but was never able effectively to enforce its policies” about the matter).

85. Id. at 713.

86. For example, many physicians work as consultants and “pseudoconsultants” for industry. JEROME P. KASSIRER, ON THE TAKE: HOW MEDICINE’S COMPILCITY WITH BIG BUSINESS CAN ENDANGER YOUR HEALTH 13 (2005) [hereinafter KASSIRER, ON THE TAKE]. Dr. Kassirer defines pseudoconsultants as doctors who, for a fee, attended industry sponsored events and meals. Id. Industry also pays practicing physicians, often significant amounts, to enroll patients in clinical trials. Id. at 9; see also LEONARD J. WEBER, PROFITS BEFORE PEOPLE?: ETHICAL STANDARDS AND THE MARKETING OF PRESCRIPTION DRUGS 46-47 (2006). Pharmaceutical representatives visit the offices of practicing physicians, leaving behind small gifts, drug samples, and free meals. KASSIRER, ON THE TAKE, supra at 7-8, 10; WEBER, supra, at 43-44. In addition, industry provides significant funding toward continuing medical education programs. KASSIRER, ON THE TAKE, supra at 8-9, 14-17; WEBER, supra, at 46.
ready openly to justify them.\textsuperscript{87} Open support for links to industry has been less public, but it does exist. It is found, among other places, in letters to editors of professional journals\textsuperscript{88} and sometimes even in “opinion” pieces in popular media.\textsuperscript{89} This section summarizes both sets of responses to such links between physicians and industry.

1. Physicians Comment on Links to Industry

Recent books by the last two editors of the \textit{New England Journal of Medicine} suggest the character of the charge against physicians collaborating with pharmaceutical companies. Marcia Angell’s book, \textit{The Truth About the Drug Companies},\textsuperscript{90} depicts the pharmaceutical industry as “primarily a marketing machine to sell drugs of dubious benefit.”\textsuperscript{91} Dr. Kassirer, who preceded Angell at the journal, strongly opposes most financial links between physicians and industry. He characterizes present-day medical conferences as elaborate advertising extravaganza for industry’s products: “Scores of beautiful men and women from pharmaceutical, biotechnology, device, and book companies greet the doctors wandering through the hall, where enormous, expensive artistic creations announce the successes of the companies’ drugs with lights, sound, food and electronic wizardry.”\textsuperscript{92} Dr. Kassirer recommends that physicians turn down all industry gifts, that they refuse to participate in drug marketing, and that they be precluded from giving lectures or publishing articles “if they have a financial relation to a company that makes a product mentioned in the lecture or the manuscript.”\textsuperscript{93} In Dr. Kassirer’s view, physicians who receive financial benefits as a result of links to industry jettison the


\textsuperscript{88} See infra notes 101, 119, 121 and accompanying text.

\textsuperscript{89} See infra notes 118, 120 and accompanying text.

\textsuperscript{90} Angell, supra note 87. In the book’s preface, Angell explains the purpose of the book is to “expose the real pharmaceutical industry.” \textit{Ibid.} at xvii.

\textsuperscript{91} \textit{Ibid.} at xviii.

\textsuperscript{92} Kassirer, \textit{On the Take}, supra note 86, at 2.

\textsuperscript{93} Kassirer, \textit{Financial Ties}, supra note 87, at 140.
values of a profession that once prized, and that should continue to prize, caring and trust above financial opportunities. 94

Similarly, John Abramson, 95 a family doctor and clinical professor of medicine, worries that drug marketing and exaggerated promises about sophisticated technology can lead to the "erosion of the healing alliance between doctors and patients." 96 Again and again, Abramson's book, Overdosed America, laments physicians' financial links with industry, and suggests that those links threaten to undermine physicians' commitment to patients. 97

The shared worry of these authors, and others sounding a concordant note, 98 is that the integrity of research on which medicine is grounded and the character of the relationship between physician and patient—which they deem central to the actualization of medicine's deepest promises—are weakened by physicians being cajoled or openly choosing to assist in securing industry's bottom line. In some imagined future time, these critics suggest, the commercialization of medicine could even eviscerate the doctor-patient relationship completely by doing away with the need for doctors. 99

In contrast, those favoring links between physicians and industry presume that the relationship between the two makes doctors more competent by helping them to take advantage of industry's innovations. 100 Among this group, responses range from surprise that anyone assumes physicians might act unethically, 101 to outrage at a "witch hunt against supposed conflicts of interest in scientific and

94. Id. at 139.
95. See generally John Abramson, The Reliability of Our Medical Knowledge As a Product of Industry Relationships, 35 Hofstra L. Rev. 691 (2006) (discussing the transformative effect of commercial funding on academic medical research).
96. Abramson, supra note 87, at 11.
97. See, e.g., id. at 120-24 (noting that pharmaceutical funding for continuing medical education skews physicians' judgment about which drugs to prescribe); id. at 241 (noting a time "when breakthroughs in medical science were driven more by health needs than by the search for corporate profits").
98. See generally Avorn, supra note 87 (discussing the influence of pharmaceutical representatives and other industry relationships on physician's prescribing habits).
99. Id. at 408-10 (imagining a future day in which patients will "directly access decision-support software on the world wide web to decide which drugs they need, and then use the internet to purchase those drugs directly"); see also infra Part IV (suggesting that medicine may split into two separate professional groups).
100. See infra notes 109-10, 114, 118 and accompanying text.
medical research.” 102 This group of commentators strongly favors financial collaboration between industry and academic physicians, generally highlights the promise of new biotechnological and pharmaceutical products, and downplays the risk of physician-researcher bias. 103

In supporting financial links between industry and practicing doctors, they focus especially on a variety of advantages that may flow to busy doctors and their patients from doctors’ connections to industry. 104 In addition, a few commentators have suggested (usually implicitly and somewhat defensively) that industry’s gifts and honoraria barely counterbalance physicians’ falling incomes, 105 and that to criticize doctors for entering into agreements with industry is to further undermine a beleaguered profession. 106

Thomas Stossel, 107 a medical school professor, is unusual among academic physicians in publicly and vociferously debunking the assertions of “prominent authorities” whom he views as having “influenced policy” in “claiming that medicine and medical science are deteriorating in a morass of commercialism.” 108 Stossel argues, in contrast to those he criticizes, that industry support for university and

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103. Stossel & Shaywitz, supra note 102. Stossel and Shaywitz report that private pharmaceutical and biotechnology companies have conducted “cutting-edge medical research” that has led to “huge advances in medical treatment, including powerful new hormones and anti-cancer drugs as well as new devices that repair heart damage.” Id.

104. See infra notes 111-23 and accompanying text.

105. Kenneth Webster, Letter to the Editor, Don’t Overregulate Health Care, ST. PETERSBURG TIMES (Fla.), Jan. 30, 2006, at 10A. The writer is identified as the executive director of the Pinellas County Osteopathic Medical Society in Palm Harbor, Florida. The writer notes that cuts in Medicare payments and other government rules are making it difficult to continue to practice medicine. Id.

106. See supra notes 74-78 and accompanying text (noting Peter Ubel’s conclusion that physicians turn to industry at least in part because industry makes them feel satisfied and productive in a way that medicine once did but no longer does).


government biomedical researchers facilitates the development of sophisticated biotechnology and the improvement of medical care:

[R]esearch is not done for free. To fund their work, university investigators obey the whims of nonprofit as well as commercial sponsors. University and governmental rules that prevent wide-ranging interactions between academic researchers and industry limit creative and economic opportunities and are a far greater violation of academic freedom than any documented interference by industry.

Stossel’s perspective suggests that medicine, at least in its academic guise, should be part of a larger industrial complex. He laments the “antibusiness attitude” of authorities on whom, in his view, the press, and thus presumably the public, tend to rely, and he disagrees with those who suggest that advances in medicine in the past forty years can be attributed to “high professional standards of physicians or their aversion to commercialism.” That view, Stossel concludes, is backwards. In contrast, he argues that commercialism should not be identified as the villain. Rather, Stossel suggests, commercialism has served medicine as well as those whom medicine serves: “It is only industry [that] has delivered these products to the public.”

Dr. David Shaywitz, another physician who favors links with industry, has challenged the notion that “university researchers” should be asked to adhere to a moral order different from that pertaining to “business people.” In this context, Dr. Shaywitz suggests, at least implicitly, that biomedical researchers work within the marketplace, and should thus be directed by the ethical rules of the marketplace.


110. Stossel, supra note 108, at 1062 (considering the implications of industry funding in light of academic freedom).

111. Id. at 1063.

112. Talk of the Nation: Science Friday: Conflicts of Interest at the Doctor’s Office (Nat’l Pub. Radio broadcast Sept. 1, 2006) [hereinafter NPR, Conflicts] (discussing physician-industry conflicts of interest with host Ira Flatow and guests Dr. Ezekiel Emanuel, Dr. Sanford Friedman, Dr. Jerome Kassirer, and Dr. Thomas Stossel); see also Stossel & Shaywitz, supra note 102 (“Little . . . technology—be it vaccines for hepatitis, heart valves, or new anti-inflammatory drugs for rheumatoid arthritis—was developed by scholars and researchers without supposed conflicts of interest.”).

113. See NPR, Conflicts, supra note 112; Stossel, supra note 108, at 1063-64 (noting that commercialism allows academic investors to bring their products to market by involving entrepreneurial investors, whose financial contributions help alleviate the high risk of failure).

114. NPR, Conflicts, supra note 112.

115. Shaywitz, supra note 102.

116. See id. (implying that conflict of interest rules discourage collaboration between university researchers and industry, and ultimately slow the pace of medical progress).
Others favoring financial links between practicing doctors and industry have written letters to various newspapers and professional journals questioning the judgment and motives of those who suggest limiting or precluding industry’s gifts to and support for doctors. One letter writer, for instance, who applauds the “free enterprise system,” opines that those decrying industry’s relationship with practicing doctors are simultaneously interfering with industry’s capacity to make “innovations” available to patients and impugning the capacity of doctors to interpret drug information provided by pharmaceutical companies.

Other letters to editors suggest that doctors have become the scapegoats for government’s inability to contain the high cost of drugs, that physicians, beset with declining incomes and increasing time constraints, yet ready to lecture at continuing medical education conferences, should not also be deprived of industry-funded honoraria, and that anger should and would be more appropriately projected at “bureaucrats, insurance companies, and legislators . . . who really run medicine,” than at practicing physicians who merely accept pens and free dinners. Others note that industry supplies busy physicians with information about new drugs and new uses for old drugs that they might not otherwise obtain. And still others contend simply that physicians in private practice, much as business people, are not likely to act irresponsibly, and should thus be trusted to resist biases that might flow from financial links with industry.

2. Assumptions Behind Contrasting Views of Links to Industry

Behind these contrasting sets of assertions about financial links between physicians and industry lie two distinct sets of assumptions

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117. See supra notes 101-02, 105 and accompanying text; infra notes 118-19 and accompanying text.
118. Bill Reading, Letter to the Editor, Gifts for Doctors Shouldn’t Erode Our Faith in Health Care, ST. PETERSBURG TIMES (Fla.), Jan. 30, 2006, at 10A.
119. Matt Beckwith, Letter to the Editor, Don’t Blame the Pharm Reps, OB. GYN. NEWS, Mar. 15, 2006, at 6. The letter writer, identified as a physician, describes Medicare Part D, which precludes governments negotiating with drug companies as “the sellout of the decade.” Id.
120. Webster, supra note 105.
121. R. Brian Barber, Letter to the Editor, Prescription: ‘A Dose of Reality’, OB. GYN. NEWS, Mar. 15, 2006, at 6. The writer, identified as a physician, challenges those who oppose links between physicians and industry to show him “a single study that says the [doctor] who goes to a free dinner with his family wrote prescriptions for inferior drugs and hurt his patients in a significant way.” Id.
122. Ubel, supra note 56, at 143; Webster, supra note 105.
123. See Robertson, supra note 101.
about medicine more generally. Those wary of or openly opposed to physicians collaborating with industry share one broad set of assumptions about the ideals of the medical profession. Broadly this group avows that medicine—as a matter of both morality and professional efficacy—should focus primarily on the healing relationship and, further, that that focus will inevitably be blurred by physicians forging financial links with industry.\footnote{124} In contrast, the position of those who would provide for or even encourage financial links with industry is grounded in a different set of assumptions—that medicine will benefit by participating actively in developments that can be actualized only with industry’s support; that medicine should not remain anchored to images shaped when medicine was a cottage industry; and that physicians, much as investment bankers and accountants, can function best by becoming full participants in the commercial marketplace.\footnote{125} To the extent that those on each side of the ideological divide fail to take account of such contrasting assumptions, discourse across the divide is, and will continue to be, stymied.

C. What’s an “Ethical” Response?: The Example of Disclosure Rules

Such contrasting assumptions support different responses to conflicts of interest created by physicians’ financial links to industry. This section examines assumptions behind contrasting positions about disclosure rules as an antidote to bias.

1. Are Disclosure Rules Enough?

Disclosure rules are minimally disruptive to ongoing practice,\footnote{126} and, perhaps for that reason, are among the most popular responses to

\footnote{124. See, e.g., supra notes 94-97 and accompanying text.}
\footnote{125. See, e.g., supra notes 100-03 and accompanying text.}
\footnote{126. See WEBER, supra note 86, at 60 (suggesting that disclosure is “simply . . . a warning that the risk [of bias] exists”). In addition to disclosure rules, rules that might be relied on to protect against bias in conflict of interest situations include: divestiture; the related remedy, recusal; and the imposition of legal penalties for behavior deemed unethical. See Daylian M. Cain et al., Coming Clean but Playing Dirtier: The Shortcomings of Disclosure as a Solution to Conflicts of Interest, in CONFLICTS OF INTEREST, supra note 56, at 104, 107-08 (indicating that, as compared with these other rules, disclosure is a less intrusive way of dealing with conflicts). In the context of academic medicine, divestiture and recusal rules would, for instance, require an academic physician who owns stock in a company that produces drugs relevant to the physician’s research either to sell the stock (divestiture) or discontinue engaging in the research (recusal). See Stark, supra note 80, at 155-56. Practicing physicians could be required to refuse gifts and other funds offered to them by industry. In contrast, disclosure obligations require only that the relevant conflict of interest be made public. Id. at 156.}
conflicts of interest created by physicians’ financial links to industry. 127

Rules requiring disclosure have been proposed, encouraged, or implemented by medical journals, 128 government agencies, 129 and professional associations. 130

a. The Growing Place for Disclosure Rules

Despite general agreement about the need to disclose conflicts of interest, not all commentators view disclosure rules in the same way. Some see them as necessary and sufficient to preclude the risk that financial conflicts of interest create bias. 131 Others deem them necessary but not sufficient. 132 Different assumptions about the physician’s role and about medicine more generally separate the two groups. 133

Disclosure rules are increasingly required of academic physicians with financial links to industry, including physicians who receive research funds, consulting fees, or other benefits from industry. Many medical journals have instituted disclosure rules, 134 and medical lecturers are asked to disclose links to companies producing drugs or other

127. See Cain et al., supra note 126, at 107-08; infra notes 128-30 and accompanying text.
128. Dr. Catherine D. De Angelis, the editor-in-chief of The Journal of the American Medical Association asks authors to sign statements in which they outline possible conflicts they may have. Donald G. McNeil Jr., Tough-Talking Journal Editor Faces Accusations of Leniency, N.Y. TIMES, Aug. 1, 2006, at D1; see also WEBER, supra note 86, at 128; Catherine De Angelis et al., Editorial, Clinical Trial Registration: A Statement from the International Committee of Medical Journal Editors, 351 NEW ENG. J. MED. 1250, 1250 (requiring that potential authors register clinical trials in public trials registry as a prerequisite for consideration of publication by member journals).
129. Among other things, rules put into effect by the National Institutes of Health in 2005 required senior officials to complete disclosure forms revealing various connections to industry, including their outside financial holdings. Jeffrey Young, Complaints About NIH Ethics Rules Dwindle, HILL, Apr. 27, 2006, at 20. About 6000 to 7000 NIH employees filed the forms in 2005. Id.
133. See infra notes 149-56 and accompanying text. Moreover, some commentators support disclosure rules for physician-researchers but would prefer that practicing doctors limit or forego collaboration with industry (thus largely precluding the need for disclosure).
products about which they will lecture.\textsuperscript{135} In 2005, the Executive Council of the Association of the American Medical Colleges, representing the academic medical community, recommended that medical researchers disclose financial interests and that the results of clinical trials be made available to the public within a year and a half of submission for publication.\textsuperscript{136} Moreover, the pharmaceutical industry, under social and legal pressure, has agreed to use the Internet to publish information about clinical trials.\textsuperscript{137}

Disclosure has not generally been required of practicing physicians who receive gifts (including drug samples) from industry;\textsuperscript{138} however, a number of commentators have begun to suggest that practicing doctors who enroll patients in drug studies funded by industry should be required to reveal financial conflicts of interest to patients who agree to participate in such studies.\textsuperscript{139}

\textbf{b. The Assumption Behind Disclosure Rules}

Broadly, disclosure rules are grounded on the assumption that people (patients, clients, and buyers) can make sensible choices and protect their interests if they are aware that those with whom they are dealing have financial conflicts of interest.\textsuperscript{140} However, a group of theorists suggest that this assumption and the rules that rest on it may be misplaced.\textsuperscript{141} Indeed, the conclusion that disclosure is effective as a

\begin{itemize}
  \item \textsuperscript{135} WEBER, \textit{supra} note 86, at 107.
  \item \textsuperscript{137} Barry Meier, Drug Industry Plans Release of More Data About Studies, N.Y. TIMES, Jan. 7, 2005, at C4. Apparently, industry's readiness to effect a voluntary code asking for disclosure was motivated at least in part by its concern about more burdensome legislation from governments. \textit{Id.} That concern was made real when New York State's Attorney General sued GlaxoSmithKline for hiding information about the use of Paxil by children. Jamie Talan, Suit Settlement: Glaxo to Reveal Drug Trial Results, NEWSDAY, Aug. 27, 2004, at A4. The case was settled, with the company agreeing to pay $2.5 million and to publish summaries of drug trials in a registry. \textit{Id.}
  \item \textsuperscript{138} Interestingly, most practicing physicians seem to believe that they are not vulnerable to industry influence, even when they accept gifts and other funding from industry. See Ubel, \textit{supra} note 56, at 143-45. Dr. Ubel writes that physicians told him that they appreciate industry's informing them about new products, and that they are unconcerned about self-serving conduct "because they are convinced that their knowledge of the medical literature makes them impervious to industry influence." \textit{Id.} at 143.
  \item \textsuperscript{139} See Williams, \textit{supra} note 131, at 70.
  \item \textsuperscript{140} \textit{Id.} at 70, 71.
  \item \textsuperscript{141} See, e.g., \textit{id.}; Kassirer, Public Distrust, \textit{supra} note 132.
\end{itemize}
practical matter may be misplaced. People tend to be influenced by suggestions and recommendations even when they know that those making them have financial conflicts of interest. In addition, those disclosing financial conflicts of interest may be less likely to correct for bias produced by the conflicting interests than those not disclosing such conflicts. Those disclosing conflicts may be motivated to “make up for” the chance that disclosure will undermine their position. In addition, knowledge of having disclosed a conflicting interest may create a sense of “moral license.” Even more, increased bias due to conflicting interests may be more weighty than increased discounting of advice by those who are informed that someone with whom they are dealing has a financial conflict of interest. Despite these limitations—

142. In late 2006, Stanford University Medical Center instituted a policy that precluded its physicians from receiving even small gifts such as pens, ended the medical center’s practice of accepting meals paid for by industry, and prohibited the center’s physicians from signing their names to articles ghost-written by industry employees. Andrew Pollack, Stanford to Ban Drug Makers’ Gifts to Doctors, Even Pens, N.Y. TIMES, Sept. 12, 2006, at C2. Yale and the University of Pennsylvania already had such policies in place. Id.

143. Cain et al., supra note 126, at 108-14. The authors asked a group of students, serving as research subjects, to estimate the population of the United States. Subjects were given an “anchor value” that was too high or too low. Subjects receiving high values were told that those offering the information were motivated to have subjects provide “an answer that was artificially high.” Id. at 111. Those given low values were informed that those giving the information were motivated to have subjects provide an answer that was artificially low. Other subjects were given random values and were given a “boilerplate” disclosure (e.g., those giving the information may “have been trying to get you to answer one way or another”). Id. The authors found that despite the disclosures, subjects “overall test scores were driven largely by the anchor suggested to them.” Id. Other studies have found that people confuse recognition of a fact with the truth of the fact. Id. at 112. Thus, people are more likely to believe information they hear often. Id. (citation omitted).

144. Id. at 114-16.

145. Some analysts call this “strategic exaggeration.” Id. at 115.

146. Id.

147. Id. at 116. The authors conclude only that disclosure does not necessarily obviate biases created because of conflicts of interest. They explain:

From context to context, whether disclosure does more harm than good depends on the balance between the discounting it stimulates compared with the “disclosure distortion” (i.e., the distorting influence disclosure has on advice given) it induces. Rather than show that disclosures always exacerbate the problems created by conflicts of interest, our goal has been to argue that disclosure cannot be assumed to always help. Id. at 117.

Despite limitations in the effectiveness of disclosure at limiting bias, disclosure rules operate widely in the corporate universe as presumptive safeguards against bias. See, e.g., Eric W. Orts, Conflict of Interest on Corporate Boards, in CONFLICT IN THE PROFESSIONS, supra note 63, at 129, 129 (noting that traditional rules involving conflicts of interest by those sitting on corporate boards require disclosure, among other things). Indeed, for the Securities and Exchange Commission, the “arbiter” par excellence of corporate disclosure, revealing conflicts of interest has become the presumptive “cure-all” for corporate misbehavior. A.C. Pritchard, The SEC at 70: Time for Retirement?, 80 NOTRE DAME L. REV. 1073, 1073, 1088-89 (2005).
or perhaps because of them—disclosure rules are among the most commonly suggested modes of safeguarding against bias resulting from financial conflicts of interest. 148

c. Views from Within

The more commentators envision medicine in traditional terms—as a profession essentially centered around the physician-patient relationship—the more likely they are to see disclosure as inadequate to protect against bias in the face of physicians’ financial links to industry. On the whole, physicians favoring traditional models of practice are least likely to view disclosure rules as adequately protective. 149 Dr. Kassirer, for instance, discounts the claim that disclosure provides sufficient protection against bias. 150 He presumes that physicians collaborating with industry are likely to be biased and that disclosing links to industry is unlikely to preclude or even balance the risks of bias. 151 In Dr. Kassirer’s view, it is generally preferable to rely on the opinions of doctors without connections to industry than on the opinions of those linked with industry (disclosure notwithstanding). 152 Dr. Kassirer envisions medicine through the lens of the physician-patient relationship, not through that of the business person. 153 He posits “patient care and personal integrity” at the center of the physician’s role and would prefer in general that both practicing doctors and research physicians minimize conflicts of interest rather than entertain, and then disclose, them. 154

In the world of medicine, as in the world of corporate commerce, disclosure rules have become popular, perhaps, as several commentators have suggested, because they are minimally disruptive to the status quo. See, e.g., Don A. Moore et al., Introduction to CONFLICTS OF INTEREST, supra note 56, at 1, 5. For instance, the Pfizer-funded supplement that was distributed with an issue of the American Journal of Cardiology, disclosed Pfizer’s support. Stephen Smith, Article Urging Heart Exams Shows Conflicting Interests, BOSTON GLOBE, July 25, 2006, at A1. The supplement recommended significantly more standard cardiac screening of middle-aged people and more follow-up tests. The effectiveness of the supplement’s recommendations had not been demonstrated; yet, if effected, it would cost Americans billions of dollars. Pfizer manufactures Lipitor, a drug that lowers cholesterol. Id.

148. Moore et al., supra note 147, at 5.
149. See, e.g., Kassirer, Public Distrust, supra note 132.
150. Id.
151. Id.
152. Id. Kassirer explains that he discounts the advice of doctors who “tout” company products, preferring to heed the opinions of physicians who “decide that patient care and personal integrity is more important than a $10,000 infusion into their bank accounts.” Id.
153. Id.
154. Id.
In contrast, the more commentators see medicine as an enterprise situated firmly in the marketplace and linked felicitously with industry, the more likely they are to see rules of disclosure as adequate protection. For instance, Dr. David Shaywitz welcomes links between physicians and industry.\textsuperscript{155} In his view, concerns about bias can largely be laid to rest if physicians’ links to industry are made “transparent” through disclosure.\textsuperscript{156}

These contrasting perspectives are illustrated by the respective positions of Drs. Kassirer and Shaywitz. Dr. Kassirer’s view reflects images of medicine as a profession distinct from the world of commerce; in contrast, that of Dr. Shaywitz favors the amalgamation of medicine and commerce. Taken together, these positions, and the differences between them, sharply suggest the parameters of the debate about financial conflicts of interest faced by physicians linked to industry. Even more, these contrasting perspectives frame a more general debate about the appropriate temper of the medical profession and the ends for which physicians should strive; and more broadly still, they reflect the debate about the future scope and nature of health care in the United States.

2. Disclosure Rules and Informed Consent

Disclosure rules presume that the communication of information levels the playing field. They thus presume that once all parties to an interaction have the same relevant information, they are equally free to make choices that will likely prove fair and be maximally beneficial to all involved.

How the debate about disclosure rules will be resolved in theory or in practice is not clear. However, the development of rules about informed consent in the context of patient care may be suggestive. The informed consent doctrine relies on a set of presumptions similar to those underlying disclosure rules.\textsuperscript{157}

\begin{itemize}
\item \textsuperscript{155} Shaywitz, supra note 102. The opinion pieces by Drs. David Shaywitz and Jerome Kassirer appeared alongside each other in \textit{The Boston Globe}.
\item \textsuperscript{156} Id.
\item \textsuperscript{157} In 1914 then-Judge Cardozo ruled that, in general, patients should not be treated unless they consent to care. Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). About a half-century later, courts began to require that a patient’s consent be predicated on information. \textit{See} Canterbury v. Spence, 464 F.2d 772, 776, 779, 783, 786-87 (D.C. Cir. 1972) (holding that plaintiff “made out a prima facie case of violation of the physician’s duty to disclose” when the doctor failed to inform the plaintiff about risks of surgery that plaintiff agreed to let the physician perform, reversing a verdict directed for the doctor, and remanding for a new trial). For more information on informed consent, see supra note 60.
\end{itemize}
The notion that, except in unusual circumstances, patient care should not be rendered absent the patient’s consent has a long history in common law. Only in the last decades of the twentieth century, however, did states widely require physicians to provide patients with material information about recommended treatment as part of the consent process. These rules provide a useful model against which to analyze disclosure rules imposed on physicians with financial links to industry.

Yet there are important differences between disclosure rules and informed consent rules. The former are aimed at precluding bias; the latter are aimed at allowing patients to participate in making their health care decisions. However, both sets of rules presume autonomous individuality in a universe—that of medical care—that was defined in very different terms only four or five decades ago. In this regard, the history of the informed consent doctrine offers a parallel to the development of disclosure rules.

Both the promulgation of informed consent rules and the development of rules requiring or suggesting that physicians disclose financial conflicts of interest created by collaboration with industry have been facilitated by the increasing significance of autonomous individuality in defining relationships within the world of health care. In both clinical and academic settings, the notion that shared information can protect against unfairness presumes a universe of putatively equal, autonomous individuals who, once provided with relevant information, are able wisely to consent to or refuse treatment (in the first case) or accurately to interpret a physician’s opinions about products produced by a company with which the physician has financial links (in the second case). Each set of rules reflects the generalization of assumptions once unique to the marketplace within the world of health care. In particular, the valuation of autonomous individuality, once peripheral to the world of health care, has long structured relationships within the


159. The majority of states now have statutory rules regarding informed consent. See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 410 (5th ed. 2004).

160. See id. at 366; Catherine M. Valerio Barrad, Genetic Information and Property Theory, 87 NW. U. L. REV. 1037, 1063 (1993).
marketplace.161 As the world of medicine merges more fully with the world of commercial enterprise, the values of the marketplace displace the values of traditional medicine.

3. New Assumptions Justify New Rules

Both rules governing informed consent, in the context of patient care, and rules requiring disclosure of conflicts of interest, stemming from links with industry, presume that the communication of information establishes parity between those providing information and those receiving information and that such parity protects against unfairness. More generally, this presumes a universe of putatively equal, autonomous individuals who, once informed, are free to make their own choices—whether about treatment (in the context of informed consent rules) or about biomedical research and pharmaceutical products (in the context of disclosure rules). Both sets of rules reflect a shift away from traditional understandings of medicine toward understandings that value autonomous individuality and that assume marketplace relationships. Such a vision was once peripheral to the world of health care. Increasingly, it is at the center.

IV. THE CONSEQUENCES OF THE IDEOLOGICAL DIVIDE WITHIN MEDICINE: ONE PROFESSION OR TWO?

In short, the assumptions undergirding the world of health care and of medicine-as-a-profession contrast dramatically with the assumptions that shaped and reflected the world of health care and the practice of medicine a half-century ago.162 On one side of the general debate among physicians about health care, and of the more specific debate about conflicts of interest facing health care providers, sit those who assume that entrepreneurialism threatens health care. This group tends further to presume that "professional" ethics are, and should remain, distinct from the ethics of the corporate marketplace and that the profession's ethical order should center around an understanding of the physician as healer rather than around the physician-as-economic actor.163 Other physicians assume that medicine can flourish as an essentially entrepreneurial endeavor, that the ethics of the profession can productively merge with

163. See, e.g., Relman, supra note 77, at 750-51.
those of the marketplace, and in consequence, that the physician-as-economic-actor can and should be at the center of the profession's self-identity.164

In effect, debate, particularly among physicians, about physicians' financial links with industry involves disagreements across a wide cultural divide.165 This divide separates those who—whether self-consciously or not—side with a traditional perspective about medicine from those who side with a perspective forged in the commercial marketplace. This distinction in the world of medicine—between traditional and commercial patterns—reflects the broader social contrast166 between a social arena grounded in the presumptions of hierarchical relationships and interdependent trust, and a social arena grounded in negotiation and choice. Within the larger society, domains of life (including preeminently the family as well as religious communities, and the universe of health care) once separated by practice and belief from the world of the marketplace have merged more and more completely with that world.167 On the whole, those within the medical community who identify with traditional approaches to medicine discourage financial links with industry. Those, however, who are ready to displace traditional approaches to medicine with approaches constructed in the marketplace, encourage the development of financial links with industry, and expect that the ethics of the profession will merge productively with the ethics of the world of commerce.

The fervor of debate and the extent of the ideological divide suggest that medicine could well split into two distinct professions. This would, in effect, entail the separate institutionalization of the contrasting visions of medicine just outlined. One of the resulting professions, focused directly on primary care, might preserve large parts of the social frame that has shaped medicine in the United States since the start of the nineteenth century. A second, distinct profession, focused on health care but not on primary patient care, might merge with industry and internalize assumptions that inform relationships in the marketplace.

164. See, e.g., Stossel, supra note 108, at 1061-64.
165. In particular, the culture divide is a divide in ideological perspective. See supra note 2 (defining ideology).
166. See discussion supra Part II.B.
167. See, e.g., supra notes 18-23 and accompanying text.
V. CONCLUSION: IMPLICATIONS OF THE DEBATE(S)

Disagreements about links to industry constitute a microcosm of more general disagreements about market-driven health care. And that discourse, in turn, is a microcosm for an even more general discourse about the social implications of blurring fences that once separated various domains of life (including the world of health care) from the freedoms and the insults of the marketplace.

Amalgamating health care with the marketplace does not necessitate abandoning ethical constraint. It does, however, mean replacing an ethic that presumed communal solidarity within an essentially hierarchical social setting with an ethic centered around choice, bargain, and profit. \(^{168}\) The two ethics begin with different assumptions and look toward different ends. One is the ethic of medicine before the last decades of the twentieth century. It is closer to the ethic of the traditional family than to that of the marketplace. The other is the ethic of the corporation and the larger world of commerce. To some extent, each ethic can be hedged with the essential protections presumptively provided by the other. Or perhaps, as suggested, medicine will split into two professions—one that focuses on primary patient care and that preserves many of the social rules assumed by medicine in earlier decades, and a second, related profession that focuses on research, depends on financial links with industry, and relies on rules that define life in the larger commercial marketplace.

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\(^{168}\) See, e.g., McArthur & Moore, supra note 162, at 985-86 (differentiating between "professional" and "commercial" cultures in medicine). McArthur and Moore describe the "fundamental act of professional medical care" as:

[T]he assumption of responsibility for the patient's welfare—an unwritten contract assured by a few words, a handshake, eye contact denoting mutual understanding, or acknowledgment by the physician that "[w]e will take care of you." The essential image of the professional is that of a practitioner who values the patient's welfare above his or her own and provides service even at a fiscal loss and despite physical discomfort, or inconvenience. There is no outside invested capital seeking returns from the physician's work.

Id.