



**SCRIPTDOCTOR: MEDICINE IN THE MEDIA**

## I Want My Med TV

By Andrew Holtz, MPH

I don't know about your experience, but a lot of the physicians, nurses, and other health care experts I encounter tend to harrumph with disdain at medical shows on TV. When I was writing *The Medical Science of House, M.D.*, I usually had to explain the show to the doctors I interviewed, because most weren't familiar with it, even though it's one of the most popular shows on TV, with 15 to 20 million viewers tuning in for each episode.

Anthony Mazzarelli, MD, however, is not among the cadre of harrumphers. He likes TV shows with medical themes. So I called him up to find out what he sees in these shows that many of his colleagues do not. He tells me that he and his wife, also a physician, are both faithful viewers of *Grey's Anatomy*, also a hot medical show.

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*"Enjoy the stories and don't get too worked up over each medical faux pas or dramatic exaggeration—and maybe pick up a few insights about how medicine looks to those on the outside, including your patients."*

cine," Dr. Mazzarelli says. "*Grey's Anatomy* is a soap opera that happens to take place in a hospital. My job is in a hospital; and so it's kind of interesting."

Dr. Mazzarelli knows that many physicians aren't as open about watching—or, heaven forbid, enjoying—

medical dramas on TV.

"It's either people are so bothered by the inaccuracies that they can't watch it or they feel some need to not admit that they watch it," he says; but he doesn't know which explanation is more likely.

I admit I'm one of those viewers who sometimes has trouble suspending disbelief; so it can be easier to just sit back and enjoy shows like *CSI* and *Law & Order* than *ER* or *Grey's Anatomy*, in part because I'm not as familiar with the daily reality of criminal justice, and so I'm less likely to notice or care about lapses in the technical details of crime shows. However, I'm not as allergic to medical TV shows as I used to be, probably due to the chronic exposure that was part of doing research for the book on *House*.

I discovered Dr. Mazzarelli's TV affection when I stumbled on an online



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article he wrote while still in medical school. The piece was about his experience during a summer internship at *ER*, where he witnessed the effort writers there made to hew to an essential accuracy in their depiction of medical practice.

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### Abigail

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guaranteed by the Constitution.

#### Majority Opinion

The 8-to-2 decision for that *en banc* hearing was handed down last month, written by Judge Thomas Griffith. Among his points were the following:

■ "Such rights are not set forth in the Constitution, and the Supreme Court has cautioned against expanding rights protected by the Due Process Clause because guideposts for responsible decision-making in this uncharted area are scarce and open ended....We must exercise the utmost care whenever we are asked to break new ground, lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of others." In other words, due process should not be used for that which it was not intended.

■ The Abigail Alliance argued that the right it claimed can be found in US history and legal traditions because government never interfered with physicians' judgment about medical efficacy of a drug until 1962 (when major amendments were made to the Food, Drug and Cosmetic Act). Judge Griffith countered by saying, "The Alliance ignores one simple fact: It is unlawful to procure experimental drugs not only because they have not been proven effective, but because they

have not been proven safe."

■ "Congress has prohibited general access to experimental drugs and has prescribed in detail how they may be studied and used by the scientific and medical communities." In other words, the law is the law.

■ The Alliance claimed self-defense principles to support its argument, saying that terminally ill people are in immediate danger of harm from cancer. Thus they should be able to use whatever medical means are necessary to defend themselves. Judge Griffith, though, said this analogy fails because it is "not about using reasonable force to defend oneself, nor is it about access to life-saving medical treatment. Rather, it is about whether there is a constitutional right to assume enormous risks in pursuit of *potentially* life-saving drugs." This case involves risk from drugs with no proven therapeutic effect and thus cannot be supported by the doctrine of self-defense, he said.

#### The Dissent: 'A Stunning Misunderstanding of the Stakes'

Chief Judge Douglas Ginsburg and Judge Judith Rogers, however, dissented. The latter wrote the dissent, calling the majority opinion a "stunning misunderstanding of the stakes." She added that the court did not come to grips with American history and tradition, "which reflect deep respect and protection for the right to preserve life."

She accused the majority of "ad-

ressing regulations to prevent fraud in the sale of misbranded and adulterated medications or safety restrictions applicable to all medicines—which says little about the historic importance of a right of a person to save her own life."

In addition to the self-defense "error," Judge Rogers said that denying a terminally ill patient the only chance to survive is a "dangerous brand of paternalism. Such intervention is directly at odds with this Nation's history and traditions giving recognition to individual self-determination and autonomy where one's own life is at stake."

#### Reactions from the Principals

Frank Burroughs said that the Alliance is "dumbfounded" that most of the judges tragically missed the merits of the case. He said it will be difficult for FDA and its supporters to put a positive spin on the court's decision.

Asked by *OT* what he meant by that, Mr. Burroughs said that he found it shocking that the eight judges didn't understand the issues they were deciding. "But there might be a silver lining in this," he said. "We're getting lots of media attention, and hundreds of people have called in support."

From the other side of the aisle, ASCO EVP and CEO Allen S. Lichter, MD, said in a statement that ASCO is pleased that the court decided in favor of ensuring that drugs are safe and effective before they are used in patients. "We are sympathetic to the


desire of patients to access experimental drugs when they have no other treatment option or when they are legitimately ineligible for a clinical trial, and we have advocated that FDA expand and clarify its expanded access program," he said.

"But the court made the right decision in this case," Dr. Lichter said. "Phase I studies are not designed to determine either safety or efficacy, so had this suit prevailed, cancer patients could receive treatments that do not work or are actually harmful. In addition, allowing access to unproved therapies could harm the ability to develop effective new drugs for all cancer patients by deterring participation in clinical trials."

#### Next Step: Supreme Court

The next step is the Supreme Court. Paul Kamenar, Esq., Washington Legal Foundation, pro bono counsel to the Abigail Alliance, said that it has 90 days to make the appeal. Then the Department of Justice, arguing for FDA, has 30 days to respond. After that, the Court meets in secret session to decide if it will hear the case. "So it would be well into Spring 2008 before we have a decision—if the court decides to hear it."

Does he think the court will decide to hear the case? "There's a better than 50-50 chance," Mr. Kamenar replied. "The case raises important issues, and it's getting a lot of media coverage."

"This is a landmark civil rights issue," Mr. Burroughs added. 



VIEW FROM THE OTHER SIDE OF THE STETHOSCOPE

## Saving My Self

By Wendy S. Harpham, MD

**M**y white coat and stethoscope lay draped over my chair, as if I'd slipped out of my office for a moment. Meanwhile, in another office, a surgeon was about to utter two words that would change my world forever: "It's back."

Soon after beginning treatment for this first cancer recurrence, I sat in a circle on the floor of my bedroom with a few girlfriends and my seven-year-old daughter. Chatting and laughing, we might have been mistaken for playing a child's game if it weren't for the stacks of "Dear Patient" letters announcing the closing of my medical practice.

While stuffing envelopes, one friend started to tell a story. "Since Wendy is a doctor..." My daughter interrupted, "Mom *used* to be a doctor."

As often happens when a child exposes the elephant in the room, an awkward twitter spread through my little party, and the topic quickly changed. But I was left wondering, "If I'm not a doctor, who am I?"

Over the next few weeks, my patients' charts scattered to doctors throughout the metroplex like feathers in the wind. At home, I fielded phone calls and read greeting cards from well-wishers expressing pity or sadness about my having cancer.

My insistence on resuming my pre-cancer exercise routine and plowing through my *New England Journals of Medicine* were transparent attempts to hold onto the old "me." But no amount of willpower could lessen my leg pain or overcome my need for midday rests.

My thoughts slipped away like wet bars of soap, making it difficult for me to navigate familiar roads and social conversations—let alone to pursue clinical medicine. I had to figure out, "Who am I now?"

"Know thyself" is a dictum that emphasizes a vital task that begins in infancy when you learn to separate



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yourself from others. Even the ancient Greeks realized the value of continuing this process throughout life.

Each individual's repertoire of perceptions, attitudes, beliefs, and behaviors evolves slowly in response to new experiences and to all the changes of growing older.

But a key element to "self" is continuity over time. So here's the challenge: linking together your sense of your past, present and future. Unifying who "you" were, who "you" are, and who "you" will be into one person—thyself.

As a physician-survivor, I'm intrigued by the social side of "self," especially a modern theory of recognition suggesting that one's sense of self depends on recognition by others. I know "I am Wendy" when you say, "You are Wendy."

This idea helps explain why I became anxious one day, after entering the hospital elevator. A colleague quickly shifted his gaze to his shoes,

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pretending he didn't see me. Intellectually I knew the problem was not me, no more than if a faucet's motion sensor failed to respond to my hand movement. My colleague was simply caught by surprise and didn't know what to say. Nevertheless, the episode was unsettling for me.

Reflecting on those days when my life felt consumed by illness, I realize the vital role my health care team played in saving my "self."

Instead of pumping data into a computer or charting notes, my doctors looked me in the eye (poetically dubbed "the window to the soul") whenever they were listening or talking to me.

The oncology social worker helped me grieve my losses, so I could see and embrace all that remained. And she encouraged me to participate in a support group, knowing that veteran survivors would both serve as role models and give me the encouragement I needed to move forward.

The nurses who cared for me always asked about my family or my non-cancer-related activities while monitoring my vital signs and administering medications. Whether it is part of their training or a natural instinct, oncology nurses are good at helping patients know who they are beyond their diseases.

Cancer can threaten more than patients' lives. One reason is that, unlike the gradual effects of aging, illness-related losses can occur almost overnight. Sexual dysfunction can

destroy patients' sense of self as sexual partners. Physical changes that impair people's ability to fulfill usual roles threaten their sense of self as independent and responsible adults. Difficulties with mobility or communication can stifle their sense of self as social beings.


A healthy sense of self is essential to recovery after cancer. So if a patient shows signs of anxiety or depression, or if a patient seems uninterested in recovery, consider the possibility of an underlying loss of "self," and respond in self-healing ways.

When you treat patients with kindness, you help them regain *self*-respect and *self*-esteem. When you express belief in their abilities or refer them to educational and supportive resources, you help patients rebuild *self*-confidence.

*"Addressing each patient as a unique individual dignifies the person with the disease."*

When your words and actions say, "You are you, no matter what is happening medically," you help patients let go of their "old normal" and recreate themselves in a "new normal" that integrates the changes and challenges accompanying their illness. In essence, addressing each patient as a unique individual dignifies the person with the disease.

Last week, someone asked my now 22-year-old daughter what I do. I was curious what she'd say. She answered, "She's a survivor. She used to be a doctor, but now she writes books for patients."

I suppose that's why I keep my white coat and stethoscope hanging just inside my closet door. They remind me of the doctor I used to be and the person I am today. 

### ScriptDoctor

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"As the show enters its eighth season this week, I once again look forward to putting my books aside each Thursday evening and, along with my classmates, peering into the action at Cook County Hospital," he wrote in the article for [www.bioethics.net](http://www.bioethics.net) in the fall of 2001.

"It doesn't bother me that maybe some of it is a little bit wrong. I certainly don't like the idea of misconceptions about medicine, but it's in the entertainment world," he says. "And to be honest with you, sometimes there are issues that come out in those shows that can spark a discussion.

"I do worry that it can put unrealistic expectations on patients, but that means we have to work a little bit harder and have good discussions with

patients, and I'm willing to take that little bit of extra work, particularly if in the long run it brings up issues we would otherwise not discuss."

As an emergency medicine physician at Cooper University Hospital in Camden, NJ, Dr. Mazzarelli lives in the real world from which *ER* springs. In addition to dealing with issues of ethics and other aspects of health care that crop up patient by patient in his clinical work, he teaches these topics at the

UMDNJ/Robert Wood Johnson Medical School. And to gain a broader academic understanding of the issues, he earned a JD degree from the University of Pennsylvania Law School and a Master's in Bioethics from the University of Pennsylvania Center for Bioethics.

But wait, there's more, as TV ad pitchmen love to exclaim: you can hear "Dr. Mazz" weeknights from 8 to 10 on *(continued on page 35)*

## ScriptDoctor

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"The Big Talker," WPHT 1210-AM in Philadelphia.

"It is a heavy load, but my wife is still a resident in internal medicine, so she still works more hours than I do," he points out.

The radio show gives him a venue for discussing all sorts of popular issues, including those raised in medical TV shows.

"The ethical dilemma of the week is usually the highest volume of calls for the entire week. People love having these discussions. And that's why they love *Grey's Anatomy* and that's why they love *ER*, because these ethical dilemmas are interesting," Dr. Mazzarelli says.

"End-of-life issues are incredibly under-discussed by patients and their families. These dilemmas arise all the time in almost all the medical shows and can serve as a starting point for discussions that are necessary and important for family members to understand each others wishes. You want them to think about it ahead of time, so it's an issue they've thought about before they actually are faced with a situation in their real life."

A few years ago, an article in the medical student edition of *JAMA* ran an article noting that regular viewing of *ER* throughout medical school would add up to about as many hours as a

typical emergency medicine rotation at most schools (Michael M. O'Connor, "The Role of the Television Drama *ER* in Medical Student Life: Entertainment or Socialization?" *JAMA* 1998;280: 854-855).

The author went on to speculate about the cumulative effect on medical students: "The popularity of *ER* among students raises interesting questions about the role of the media in shaping aspiring doctors' perceptions about their chosen profession. Does the show cultivate the development of spurious attitudes toward various medical specialties? Do *ER* physicians set the con-

temporary standard for the ideal physician? Although most will agree that *ER* provides a captivating escape from one's studies, a latent socialization force may also operate in tandem with its entertaining storylines."

Dr. Mazzarelli said he doesn't worry too much about it.

"I think sometimes we overanalyze these fictional shows and we take them a little too seriously," he says. "The bottom line is that after a while you don't watch these shows for the medicine, you watch them for the characters. Both *Grey's Anatomy* and *ER* are character-

driven shows. Maybe in the beginning you watch the shows because you have an interest in medicine, but that's not what keeps you watching. It's because you want to see if McDreamy and Meredith are going to get back together. You don't watch because you wonder what medical conundrum is going to come on this week."

So sit back, enjoy the story, don't get too worked up over each medical faux pas or dramatic exaggeration—and maybe pick up a few insights to how medicine looks to those on the outside, including your patients. □



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Patients should be frequently monitored for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary.

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†PE—pulmonary embolism.  
IU—international units.

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