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Meeting Transcript
November 8, 2007

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SESSION 1: THE HEALING PROFESSIONS/ MEDICINE
CHAIRMAN PELLEGRINO: Good morning. Welcome. The first act of business is to recognize Dr. Daniel Davis, the Executive Director of the Council, who is the official government representative at this meeting. Dan, good to have you with us.

This meeting will be dedicated to several subjects we’ve been dealing with over the last several meetings, and I’m hoping that each and every one of you on the Council will, as you make comments and any comments you want to add later, comment on the appropriateness of these subjects and whether we should or should not pursue them and in what way the Council can make a contribution to these subjects as well.

And without further ado, I will do as we generally do, begin without a formal introduction. For the members of the Council, the background of our first speaker, Arthur Frank, is in the agenda book and I will identify him as from the University of Calgary. He and I have had a meeting some years ago. We were trying to reconstruct when it was. His memory is better than mine, but neither of us could recall that. But I’m sure, since I wasn’t talking, he probably had a good time.

Dr. Frank is going to take up the question of the healing professions, medicine, being a paradigm case, but certainly not the only one of the healing professions. And we invite him to make his presentation, following which we will have a member of the Council open the discussion.

Dr. Frank, you may use the podium if you wish, or the chair, whichever you like.

PROF. FRANK: No. I was just figuring out how to turn my microphone on. Thank you, Dr. Pellegrino. Thank you for inviting me. And because our topic, my topic, this morning really is how to achieve kindness in highly administered bureaucratic settings, I want to thank Emily Jones for her help getting me down here. She exemplified the qualities I want to describe this morning. I’m not sure Emily is still in the room, but thanks very much to her.

My presentation this morning attempts to address the Council’s concerns by adding a more practical dimension to the project expressed by the title of my most recent book, *The Renewal of Generosity*. Simply put, even when healthcare offers good treatment, it too rarely offers generous care. My concern is how care can be, not only safe and competent, but also generous.

Because I appear in a series of speakers on the professions, let me begin with a preface in which I’d like to reframe the question of professional crisis and renewal. My perspective is formed in part by my work with practicing physicians and nurses, but it’s also formed by several decades of teaching sociological theory, in which the figure of the professional has a specific and crucial role. How I see things is also affected by my currently writing a book about how stories enable human life.

I understand social theories as narratives that seek to make livable the tensions of modernity. One tradition of theory undertakes a defense of modernity, and certainly since Marx, modernity has required defending. In these narratives of modernity, the professional is cast to play the role of hero. I mean hero in the tradition of Germanic mythology, in which the trouble that animates the story is a crack in the foundation of the house of the gods. The hero exists in order to hold that crack together, lest it expand and bring down the gods’ house. In other words, life is a constant struggle between forces of light, the gods, and darkness, which the fall of the gods would bring.

The hero is one who, in his being as much as in his deeds, sustains the forces of light that are always threatened by this crack in the foundation, and that’s a core narrative. Sociology takes up this narrative, casting the professional in the heroic role of holding together a modernity that even its defenders admit is cracked.

At the start of the 20th century, Emile Durkheim hopes that professional associations will mediate between governments that are too big and distant, and families that are too small and local. Max Weber emphasizes the professionalism of the administrative bureaucracy. Thorstein Veblen, for whom modernity is definitely cracked, looks to engineers to save the world through their technical and managerial expertise. And so it goes in this tradition, culminating at mid-century with Talcott Parsons, for whom the physician represents the historical telos of the professions and the measure of other professionals.

For Parsons, the physician unifies the competing aspects of modernity: the drive to personal gain and the drive to collective good. In the physician’s independent practice, he — and my pronoun reflects that I’m talking about the 1940s and ‘50s — is an entrepreneur, making a living from fees received. But in the physician’s professional obligations, he puts the welfare of his patients before financial gain. Thus, the professional-as-physician is the hero who, in his being, embodies the reconciliation between the forces of capitalist self-aggrandizement through financial gain — which is the typical motive of the businessperson — and the forces of collective good, represented by religions.
and state welfare institutions. The professional physician literally heals modernity, holding together the cracked sides of its internal fault. Following Durkheim, Parsons understood this crack as the potential for forces of egoistic self-aggrandizement — unleashed by capitalism — to overwhelm obligations to collective need.

At least two questions can now be asked, and I will only pose these, not pursue them. You have already heard speakers who have shed considerable light on both of these questions.

The first is: to the extent that this theoretical idealization of the professions, especially of the physician, was ever actually true as a representation of people's lives and experiences, was that because particular historical circumstances came together for several decades, but this specific figuration could not be expected to persist? Is it possible that in mid-century America, there was a historically unique balance? Physicians had sufficient resources of knowledge and technology to be able to offer real benefits to many patients, but these benefits were still sufficiently limited so that demand was not yet excessive, and the means of medical practice were still sufficiently low-tech and low-investment that there was not yet an excessively tempting amount of money in play? I pose that as one kind of question, or as a hypothesis for a historical investigation.

The second question follows from the first and is the point of this preface. If the heroic narrative has had its day; if as Max Weber once wrote, the light of the great cultural problems has moved on, what is left? Here I get to generosity. What is left is what I have called fundamental medicine: two human beings in a room, one who is in need, and the other who has at least limited resources to meet that need.

There is a crack in the foundation of this room. One side of this crack is a level of need that can overwhelm the capacity to offer medical care. Today, the needs of patients have a potential for almost limitless expansion. Some of this expansion is in response to the perceived benefits of medicine. A different kind of expansion stems from medicine's job as a repair center of last resort for people whose bodies reflect the physical degradation of the condition of their lives and work, because there is no other reliable care system.

The other side of the crack is the increasing commercialization of medicine that Dr. Relman spoke about. I see commercialization as Dr. Relman does. Yet, my own meetings with medical students, unsystematic as my sample is, support the recent study by the American Association of Medical Colleges finding that young physicians, as a group, are less interested in massive financial gain than in living balanced lives.

If I find those young physicians' attitudes to be a cause for optimism, I also recognize that the directions of the profession are being set by forces well described by Drs. Sheila and David Rothman. Whatever individual doctors may want, physicians are being cast as the point-of-sale delivery agents for a huge commercial enterprise, including but hardly limited to the pharmaceutical industry. This enterprise wants its products to reach consumers. Like all good capitalist enterprises, medical commerce has scarce interest in matters of equality, specifically no interest in how the distribution of its products affects what we can call the social gradient — who has access to what resources, in order to advance their lives in what ways, including marketplace advancement. For the medical-industrial complex, "consumer-driven" means gearing the nature and the delivery of services to those with the greatest ability to pay.

So how can healthcare — not just physicians but all those whose work and whose presence affects patients — how can healthcare remain generous, in the middle of this crack between expanding need and demand, and expanding pressure to deliver treatments as commodities? And, why do I keep my focus on this small room in which fundamental medicine is being practiced, when as I have emphasized, so many external factors are pressing in on that room, affecting what can happen there? Why, when so many big issues seem to require macro-level reform, do I keep on thinking so small?

To create a narrative of generous medicine, I have needed a helper, and this has taken the form of a personification that I call the Dialogical Stoic, which is a slight philosophical joke. Yet, the Dialogical Stoic reflects real needs of both seriously ill patients and professional caregivers. I begin with the needs of patients, because my own direct experience is on the side of the person in need.

Being seriously ill requires two complementary but distinct capacities. One is the capacity to be alone, both in the literal sense of being by yourself and in the expanded sense of feeling you have only internal resources to get you through what you confront. Stoicism begins with sorting out what a person can control from what she or he cannot change or affect. The point of this differentiation is to take the fullest responsibility for what is yours, and to be neither distracted nor distraught by
what is not yours. That is one competence required of the seriously ill. The complementary competence is living a life that is dependent on the physical care and the moral recognition of others. I call this competence dialogical because it involves a play of voices. In care that is dialogical, the voice of each comes to speak the voice of the other; boundaries of self and other remain, but become permeable. Each sees and hears him or herself in the other, not as identification, but as an effect of mutual recognition.

Healthcare professionals also have their Stoic moments and their dialogical moments. Here I include as professionals everyone from physicians and nurses down the institutional hierarchy through technicians to admission clerks and porters, because all these workers are pursuing a calling of offering themselves — their bodies as well as their skills — to other humans who are in need.

For professionals, the Stoic moment is a refusal of the alibi that because my work is affected by so many rules, constraints, and codes — from billing codes to codes of conduct — any limitations in how I act reflect the limitations of my situation and supports, or lack of supports. Again, the Stoic begins by taking account of all that she or he cannot be responsible for, but not as an alibi. Instead, the Stoic uses this separation as a foundation for taking the fullest responsibility for what she or he can do, living a life responsive to others’ needs.

The complementary dialogical moment for the professional involves recognizing what it means to be present to those who suffer. Dialogical presence is physical — one’s body is close to the other’s body — it is moral, and it is mutual. The dialogical moment involves seeing beyond all the limitation and frustration to the fulfillment described in the testimony of so many caregivers. In caring for the suffering other, they discover that their own deepest needs are being met. Like all ideals, this dialogical ideal is easily overwhelmed. The question is how to sustain its possibility.

From the perspective of the Dialogical Stoic, the problem in contemporary healthcare is that everyone — patients and their families, physicians and other healthcare professionals — everyone is waiting for Godot, where Godot is the algebraic X that is filled in by whatever comes from elsewhere and sustains the fantasy that something-from-elsewhere is what we need to solve our problems and restore meaning and goodness to life. For some person, Godot is a breakthrough drug. For another, it’s reform of the reimbursement system. For yet another, Godot is new management that will open its eyes and actually see how its policies affect professionals’ ability to care.

The problem of care, of generous care, is that so many people feel like their work and lives are hostages to what only someone else could provide, but is not providing for some reason or another. So people act as if they can only wait, and become more demoralized, and eventually seem to forget what they were waiting for. People become what Robert Merton, back in the late 1930s, called ritualists: they keep on fulfilling their job requirements, but they have given up on their work fulfilling the values and goals that they once felt invested in. What both Stoicism and dialogism teach, as a practical ethic, is how to avoid living your life like a hostage. My positive word for this negative injunction is generosity.

People do not feel like hostages because of some failure in their personalities. They feel that way because the material conditions of their lives and work encourage that feeling. Healthcare today is heavily routinized, if I can use a sociological term that seems most appropriate. That is, caring is reduced to routines that have their specific jargon and algorithms. In the United States, care is mediated by Length of Stay data, as a measure of hospital and physician efficiency; in Australia, there is protocol-based nursing; in Canada, we have clinical pathways that determine exactly when the patient is supposed to need what or be ready for what, culminating in discharge. These routines reduce professionals — a term implying both competence and independence of judgment — to workers, implying those who implement directions from elsewhere.

I want to recognize two aspects of this routinization of care. One is that it begins with a generous impulse, and the other is that it demoralizes patients, families, and professionals. The generous impulse is to offer the highest standard of care to the greatest number of patients. Unfortunately, standardizing care means that particular patients will suffer because their needs do not fit the standardization. Serving the greatest number means that some will suffer so that others can benefit. The impulses behind routinization may be generous, but being the object of routinized care, as a patient, or having to practice routinized care as a professional, is demoralizing, because sooner or later, either one’s own needs are denied or one has to act as the agent of such denial. Routinization sucks the generosity out of people, leaving them hollow.

If there is, today, a crisis in the professions, I see it on two complementary levels. On the level of fundamental medicine, the crisis is the disconnection between, on the one side, a patient and a family for whom they deal, right now, with this illness is the crucial measure of their moral
lives. On the other side of this disconnection is a professional who is trying to meet an administratively imposed standard of expectations, and who has been shaped by those administrative standards into a functionary, for whom this patient and family present nothing requiring distinctive recognition. To use a Canadian metaphor, these are the two solitudes of healthcare. And each does feel utterly alone.

So after all this exposition, why do I think small? Because despite all the external pressures on the two people in this small room where fundamental medicine is practiced, there can be dialogue between them, and in that dialogue there can be recognition of suffering and there can be care. For this dialogue to happen, each must effect a stoic separation between what each remains capable of — which is responding to the face of the other, in its singularity and need — and what each cannot be responsible for, which may include the length of time they have together or the scope of services that can be offered.

I think small because I believe that people can have the courage to stop waiting for whatever Godot is supposed to make their lives better. People can begin to do what they can, with what they have now, to make their lives better. An important corollary belief follows. The most effective and efficient way to bring about changes is to act as if they had already taken place, and the benefits can be realized right now. Utopian as this belief sounds, it reflects a realistic recognition that the 20th Century is littered with the bones of well-meaning reforms that either went nowhere or turned distinctly bad. Maybe the lesson is that whatever macro-reform is enacted, its eventual effects will depend less on the higher-level planning of that reform and more on the spirit — the morale and the morality — of people who implement those reforms at the point of practice. The fate of any reform seems to hinge on the character of people who implement that reform. So, of course, I agree health care requires structural reform. But that is not a crisis. That is an historical constant, and it's definitional of modernity. The crisis is the moral character of those who are practicing healthcare today and who will implement changes in healthcare tomorrow.

How to enable people's capacity to express moral character brings me to practical generosity. Here I offer a proposal that truly is modest, at least in its implementation. What seems realistic is to draw upon one of the great institutional innovations of the last century, which is the recovery group. Recovery groups are justly criticized from multiple perspectives. Yet, the fundamentals of the recovery model appeal to a Dialogical Stoic. At the core of the recovery model is sorting out what a person can control and cannot control, and resolving to work on the former and not be demoralized by the latter. Moreover, recovery groups trust the power of dialogue to affect lives. Recovery dialogue is often overly constrained by group ideologies — it's by no means perfect — but the group is committed to hearing and learning from each other's stories.

What I offer, as a plan for practical generosity, is a one-off recovery model, a 13-step program for someone whom I think of as a recovering caregiver. Recovering caregivers suspect that in the battle for their hearts and minds, the best part of their moral selves has been lost. That is, a capacity for care as response of one human to another has given way to a routinized response of workers to clients. My prototype candidate of someone who needs to be a recovering caregiver is the physician who is quoted by Charles Bosk in his book, *All God’s Mistakes*, about genetic counseling. Bosk is asking this physician how he can keep on working in a hospital where things happen as they do. The physician's response epitomizes the loss of a person's heart and mind: "What you have to do is this, Bosk. When you get up in the morning, pretend your car is a spaceship. Tell yourself you are going to visit another planet. You say, 'On that planet terrible things happen, but they don't happen on my planet. They only happen on that planet I take my spaceship to each morning.'" What does this spaceship physician need, to renew generosity in his life? In offering my 13-step recovery program, I am well aware that multiple professional associations have worked hard to produce different pledges, codes, and guidelines. Why do I, without the benefit of even being a healthcare professional, have the presumption to offer another statement of good intentions? The answer has to be that mine are somehow different; how? What I find in reading the pledges and codes of professional associations is that they take everyday practices up into the elevated thin air of principles. These principles are laudable, but they often sound too much like ceremonial pronouncements made on ritual occasions; they seem disconnected from the practical realities that I hear in professionals' descriptions of their frustrations and joys in medical work. I have tried to write not principles, but behavioral: my statements seek to help people to reflect on whether they are acting as they want to. I've tried to write statements that seem simple, but then have a kind of aftertaste that leaves people wondering whether they are actually doing what the resolution recommends, and what the extent of that resolution is.

I have also tried to include moments of permission in my one-off 13-steps. Too many pledges are all obligation. Stoicism balances responsibilities with letting go; letting go is prerequisite to assuming...
responsibility. So several of my statements allow the recovering caregiver to let go, by encouraging reflection of what the person cannot take responsibility for.

Unlike other 12-step recovery programs, I offer these 13-steps not as a canonical statement that must be observed without variation. These steps are an opening to peer dialogue that will lead to revision of how steps are worded, to the deletion of some steps, and to addition of others. I would be most happy if peer groups of two or three or twelve took my 13 steps apart completely and wrote their own. What would count for me is that I had at least instigated that degree of commitment to moral reflection on practices of care, and that much dialogue about practice. I believe that if the Stoic from whom I have learned the most, Marcus Aurelius, were to return to earth and see people reading his injunctions for living, his comment would be that it was fine to read his writing once to get the idea of the exercise, but what counted was people undertaking the work of writing their own injunctions, reminding themselves of how to meet whatever challenges their ability to sustain their integrity of character.

Here, then, are my 13-steps — and there’s a handout that will be passed around as soon as I’m finished. Or, my 13 provisional resolutions, offered for dialogue and revision by professionals who feel a need to reflect on what care means in their lives and their conditions of work.

1. Any expertise or skill I offer is based, first and last, on offering my presence as a fellow human being.

2. My words and gestures, and the attitudes I project through my actions, affect the healing of my patients, the morale of my co-workers, and the moral self I become.

3. I am responsible for how I offer care, but I do not work in conditions of my own choosing.

4. I forgive myself for doing what my working conditions require, but forgiveness requires working to change whatever is detrimental to care.

5. If I ever feel my work is out of my control, then I have ceased to be an effective professional and need either a day off, or to lead a protest, or both.

6. I refuse to blame patients when their troubles reveal inadequacies of either professional institutional capacity to care or professional ability to treat.

7. I will recognize who — patient, co-worker, or myself — pays what price in which currency — money, time, physical risk, dignity — to keep the institution running.

8. I will ask myself: By telling or not telling a truth at this moment, whom is that serving?

9. I refuse the self-defense of blindness to the gap between my patients’ needs and what care I can offer.

10. When I reach the limit of my ability to provide care, I will recognize what remains uncared for and offer appropriate expressions of regret.

11. Faced with patients or co-workers whom I find difficult, I will first ask myself what difficulties they confront, and how they are struggling to hold their own. If recognizing their struggle fails to bring resolution, I will protect myself.

12. I will never forget that any person’s suffering is every other human’s vulnerability, including my own.

13. I will seek, in each person, what is most admirable, enjoyable, and soulful. I choose to respond to these qualities with what is best in me.

I emphasize in closing that implementing this program for the renewal of generosity requires nothing more than two people sharing an aspiration to put caring back at the center of their professional lives. There is no need to take control of a professional association, or to plan a national strategy for equitable healthcare, or to alter the corporate development and production of health resources. There is no need for agreement on what big goals might mean or how to achieve them. There are just practices of care, reflected upon and refined through dialogue about how we — as some group of professionals, including the physicians and the porters — want to live our working, professional lives, and what we owe to ourselves in how we care for these fellow humans, our patients.

As people experience themselves being the caregivers they choose to be, they will feel less like hostages and more like those whose lives fulfill a calling. Eventually, my belief, and maybe my faith,
is that when enough small groups put generosity into practice, then institutional policy changes will follow. The changes that have the greatest chance of having an effect and of turning out for the good are those that enable what is best in what is already being done. These changes will seem natural ways to catch up with practices that have already shown people what they can do, to be who they want to be. Then people will say, we did it ourselves.

Thank you, Dr. Pellegrino.

CHAIRMAN PELLEGRINO: Thank you very much, Professor Frank. We’re very much appreciative of your insight into the beginning and the end of medical care which is with the bedside of the patient, the clinic of the patient, and the confrontation person-to-person.

We have asked Dr. Rebecca Dresser, a member of the Council, to open the discussion. Dr. Dresser?

PROF. DRESSER: Thank you. I’m honored to begin because I’m a big fan of Dr. Frank. I was introduced to you and your work about 12 years ago by another Council member, Carl Schneider, and at that time, you had just published your book, The Wounded Storyteller.

In there you wrote, "People who tell stories of illness are witnesses turning illness into moral responsibility." With power and compassion, you have been such a witness and many have benefited.

Now in that book and your earlier one, At the Will of the Body, your thoughts about fundamental medicine came primarily from the perspective of the patient. And there’s appreciation there for health professionals, but there’s also a lot of anger and criticism about their behavior. Some of your other work though and the presentation today focuses more on the professional and from the professional's perspective of healthcare, so perhaps you have come to feel more generous to healthcare professionals in the time that has elapsed. If so, I’d like to hear about that evolution. You elude to it in the reading, but I’d like to hear more about that and also how your experience as a seriously ill patient connect and fit into the practices of care that you’ve presented to us.

And then finally, in the article that we read, "Generous Medicine," you talk about a conversation that physicians can have with patients if they want to help the patient, and you describe some basic questions physicians can ask that are focused on how has the illness changed your life. I wonder if you have some questions, thoughts, about more specific situations; for example, the situation of breaking bad news to a patient, talking to a patient who is refusing treatment that the physician thinks is beneficial. What questions might the general physician ask patients in those contexts?

CHAIRMAN PELLEGRINO: Dr. Frank?

PROF. FRANK: I assume this meeting is going late into the evening to respond to all of those.

Thank you for that lovely summary of where I’ve been and excuse me if I reply fairly selectively to an extremely global question that you’ve put to me.

You’re right. I have changed my attitudes toward professionals. Maybe because it’s been, very happily, a long time since I’ve been seriously ill, although I’ve continued to go through serious illness with people who are very close to me, and I’ve seen both their frustrations but also how incredibly much they’ve been helped by physicians.

It’s also that so many physicians over the last 15 years have been so extremely kind to me in terms of, not just in inviting me to speak various places, but really taking me into their confidence and talking to me so candidly and movingly about their joys and frustrations, as I said, and I’ve really gotten to know these people.

This year I have the privilege of having a group of medical students whom I meet with on a sort of regularly irregular basis and just talking to them about everything they want to hold onto as they move into professional life, and I want so much to do what I can to help them to be able to hold onto what’s best in themselves.

And, of course, we have a long literature on what happens to medical students, and it’s one of the most depressing literatures you can read because, ever since Boys in White studying medical students back in the late ‘40s, the story has been exactly the same. You start off with these incredibly idealistic, highly motivated young people, and you produce cynics and skeptics. And really the only thing that’s changed much in that literature is where the production takes place, whether it happens toward the end of medical school or now it seems to happen more during residency periods, but we
could call it the institutional production of cynicism. It's really the lesson of that literature.

So how do we help these people stay who they are? That's been the big question for half a century. And people are doing an enormous amount of work about that. I also work with people involved in medical education. They're acutely aware of this. So I'm trying to do my small bit to contribute to this effort, and that's part of the presentation today.

In terms of my experiences, it's a matter of thinking through everything, whether it's a medical-economic question or whether it's a question of professional identity in terms of what its impact is going to be on those who are most vulnerable and most in suffering now.

The fundamental asymmetry of the medical encounter, of what I'm calling fundamental medicine, may not be differential expertise, may not be differential access to resources. It's the fact that something is going on in one person's body which is terrifying. They're frightened. That's their vulnerability. The rug is getting pulled out from under their lives. And the other person has the grace to be enjoying another day at the office, and that's really the divide that has to be crossed.

So how do we think through every single question in terms of what it is like to be this person who is perhaps in pain, most certainly afraid, uncertain, wondering where this is going to go? How do we always see it from that perspective and the perspective of the person who has the least resources to deal with the situation? I take a lot of this from liberation theology which I think is extremely important as a moral foundation.

In terms of your notion of questions, rather than pose more specific questions on this occasion, that is questions — you mentioned bad news, or patients who seem ill-advised and refusing treatment. I think that way lies at the core of these impasses, these sticking points — it's very often that one person simply doesn't know enough about how the other person is trying — and the phrase I like to use — trying to hold their own. And a lot of the impasses can seem much more resolvable if some background questions are asked about the person's life if you maybe just step back from the immediate impasse and find out something about where this person has come from.

The greatest rounds I was ever asked to do in a hospital, the greatest in the sense of the most fun and, I think, the most productive, was a small hospital in Chicago, and they brought in someone who was their "difficult patient" for me to talk to. And I started off talking to her, but not about the things that were of concern to the medical staff at that moment. I noticed that she was born in the early '20s. I said, "So you were kind of eight or nine when the Depression started. Did you notice this? Did it have much effect on your life?" Wow, did it ever, and she took off, and she told us this incredible saga about a life that included all kinds of enormously difficult circumstances. And I asked her just some kind of generals helping along the way to keep her telling the story of her life.

The two points of this: One, when we got to the end, the attending physician whose patient she was officially, although she was cared for by everybody there, pointed out that it had only taken 20 minutes. Now this is someone with advanced diabetes, at that point was in and out of the hospital monthly, eventually was in the hospital fulltime. For the hours of care, the days, you know, all the institutional resources, 20 minutes was nothing.

The second point was that in the followup that he was kind enough to send to me a lot of these difficulties just seemed to fade away because she felt she was being treated by people who knew who she was, where she came from, how she was trying to hold her own, and how her present difficulty was part of that holding her own. And they realized who they were dealing with, that this morbidly-obese, eccentric old lady had a story. It was an incredible story.

Thanks.

CHAIRMAN PELLEGRINO: Thank you very much. The paper is now open for discussion. Bill?

DR. HURLBUT: Well, I think you’ve clearly identified and described the disease, but I want to ask you about the diagnosis a little bit and the etiology, if you will, implicit in the diagnosis.

You began with this comment about the crack in modernity, and reflecting on that as you were speaking, I was thinking about the meaning of the word "modernity," which has an interesting kind of source in that it’s rooted in the notion of a concept of a measure or a manner, particularly of or pertaining to present times. And it comes from the same Latin root, I guess, that the word "module" does, the idea that there is a kind of interchangeability of things and things — and we all know what this is about. It’s a sense of, well, this is our way of seeing the world. This is our era. It’s not every era.
And what strikes me is that you're calling for very deep things here, the concept of generosity and its relationship to both suffering and gratitude. You cite this notion of this spaceship, and I remember very well my early days of training in medical school, what it was like. You enter into a realm that is largely sequestered into a special zone in our civilization. It's not in a lot of past (and some present) societies. But suddenly as a medical student you're thrown into an encounter with suffering, with death, that you don't really experience, at least not in most suburban existence and relatively affluent urban existence. It's a dramatic and powerful encounter.

You immediately are besieged by a reality that is not one you've adjusted your life and philosophy to for the previous decades. And medical students typically go through a phase that's sometimes called "medical student disease" where they start finding the symptoms of the diseases they're encountering in their own bodies and actually are going through a very trying and troubling and sometimes very difficult transition to an acknowledgement of their own frailty and finitude, their own mortality actually.

Well, what I want to ask you about is basically this. It struck me at the time of my training and it strikes me now that the crack in modernity is really a crack in creation or at least in the way that creation is operating.

It's the reality of something that is not easy to accommodate, namely, death. And you've laid out some very good ideas here. I certainly concur with the central themes of your 13 steps. But I wonder if the diagnosis isn't deeper and if the cure more fundamental; namely, to say that we need a prevailing philosophy in our civilization that actually directly contends with the mystery of human life and death.

I think when I've observed people caring for others in the manner that you describe it usually comes from something very profound where they are no longer hiding from basic reality but have found a way to both reaffirm what you are calling the vulnerability of others. But also, it isn't enough to be fellow victims of a horror. It requires hope. It requires some source of hope.

And so I just want to lay that out for your reflection because part of the modern world has been a very materialized — I don't know how to say it exactly — a very material vision of what creation is. We see the crack as almost a material crack as opposed to a disorder of spirit or meaning.

And I wonder if in moving beyond religious traditions, moving beyond even the feeling of the recognition of what literature usually has supplied in its cultures into a realm of the new and the modern, we might have actually left behind some of the solution.

PROF. FRANK: Well, a lot of people have said exactly that. And again, this is a huge issue that you've put on the table. I really love your phrase, "no longer hiding from basic reality." And rather as seductively enticing as it would be for me to trot out my favorite philosophers of modernity and the ways in which they've responded to your expanded version of this crack, actually I was trying to discipline myself today and stay away from the expanded vision to a somewhat narrower vision because I guess my own tendency is to go exactly where you're going and see the more expanded issue, and we can talk about ways in which an enterprise like sociology is really a secularization of what was previously a theological vision and trying to handle the same problems. So I agree with you exactly. I'm just a little reluctant to go there.

Where I would like to go from what you've said are the comments you made about your own training and the way you felt. The University of Calgary has a good medical school. I know a lot of the people who teach there. Some of the people who teach there are also people who care for me as physicians, and I know they're really good.

When I asked my medical students to take a look at the draft of my 13-step program — and they were very kind in helping me refine various things — one of the things that was fascinating was how many of these points, all of which I take to be pretty obvious, they said, "Nobody has ever said that to us. Nobody has ever raised that issue." I mean, the need that I hear reflected in the things that you've said, very moving things about your own training, why isn't there someone there raising these issues in medical schools?

The most contested thing that I see in the medical schools that I visit is time. They're just constantly having curriculum fights over very small units of time and who gets an extra hour lecture block and all of these things and, you know, if they want to introduce something new, it's like the priests of Nemi. Someone has to be killed off so that someone else can get, you know, their lecture slot fitted in for their kind of thing. And these are not handled in generous ways. They're handled in quite Machiavellian ways very often.
Why aren't these students getting the kind of — well, I'll use the contemporary word "mentoring" — but that's a more secularized word than I really mean. Why aren't they getting the mentoring, counseling, advice from our more senior people, what our first nation's people would call "elders," helping them adjust to this divide that you've described so well, because it is overwhelming.

One of the most interesting subgroups of medical students are those who become seriously ill either during medical school or they enter medical school having already gone through an experience of serious illness. And if you attend to their voices, you can learn a great deal. They generally feel quite alienated, quite marginalized. The medical school doesn't have any particular vehicle for taking their experiences onboard and treating them as privileged witnesses again or, in an anthropological sense, privileged informants. That really says a lot about what's missing in medical schools nowadays.

So I think the value I would take from your reflections are what's missing and, without getting to the kind of usual curriculum wars, how do we find ways to make this available to these students, because there is advice from elders that can certainly ease this.

On one level, everyone just has to confront these things him or herself and there are ways in which that's just going to be a rough passage for some people. There are also ways in which having someone guiding you, the proper companion, can make an enormous difference.

CHAIRMAN PELLEGRINO: Thank you very much. Dr. McHugh?

DR. McHUGH: Dr. Frank, I very much enjoyed your talk and want to emphasize before I ask another question what I most appreciated about it.

First of all, I appreciated the historical setting in which you pointed out the transition from physicians in the '50s to now with the advance of technology, the intensive care units, the things of that sort that make our capacity so much greater for the care of patients, for the treatment of their diseases, and at the same time so much more expensive and, therefore, costing us in various ways in our professional aims, purposes, and often feeling abused in the process by the managers of those technologies and those institutions that provide these things.

It is said, by the way, though as usual, that the problems of today are due to the solutions of yesterday. I can tell you that certainly in this case, it is true. What we could do before the intensive care unit came with all of its equipment and the discoveries of medications and technologies it made possible, I remember very well, and I now see and am, in fact, the product of that kind of care that has extended my life even, as I understand, more of the demands that were put on the doctors and the nurses in that process. So I very much appreciated that vision that you brought to us.

The second thing I very much appreciated was, in your discussions here and even very much in your 13 points that you are emphasizing, that we should be self-questioning people in the process as professionals. The greatest and most thoughtful people in any profession, but particularly in medicine, should be people who are questioning themselves and questioning their processes as they work at what they're doing. And in that way, by self-questioning, they can improve, not only themselves, but also the organizations that they're in. I very much appreciated those points that you're making and would align myself with a lot of what you're saying.

But I have to say that there's a problem really for someone. Perhaps it's because I was educated in the '50s, and there may have been at that time a posture of development that was different. I don't really think it is radically different, but it might have been a different cast in the context of that time.

But at that time what was very clear was that one of the things expected of us as doctors that are not mentioned here would be that we were going to be taking risks, even risks at great cost to oneself, to become a successful and quality and real physician and that these risks were deep and important.

In fact, if I can tell a little story — you believe in stories. I believe in stories up to a point. They persuade and seduce as well as to inform, but here's a little story.

When I was graduating from medical school, the leading physicians in the departments of medicine in the three Boston hospitals came to talk to us about why we should go to the Brigham, to the BI, to the Mass General, the Boston City Hospital. But the only one I remember was Dr. Herman Blungard, the head of medicine at the Beth Israel Hospital, and he got up before us all bright and shining physicians-to-be and he said, "Well, if you come to the Beth Israel, I have something to offer you. It's called poverty, chastity, and obedience. And out of that process though, you will become an excellent physician of the kind that you wanted to be."
It was a direct challenge in this way, and I'm trying to voice it in this way, to this beginning of what you said, which was that in the contemporary era when you talk to young physicians, or young medical students anyway, that what they're looking for is balanced lives. And I submit to you that that is a non-risk-taking position that, if you can't at the age of 25 or 26 be willing to say, "I'm going to venture out and see what happens and do what I can for the benefit of my patients, and I hope I'll get a balanced life ultimately and I hope I will have something meaningful to show," I'm not sure that you can be anything ultimately but a cynic in the long run, that ultimately you need to have the capacity to say, "I'm going to give it my all," and in that way have what I believe is the ultimate aim of this development, by the way, often developed by example and not necessarily being taught in the form of ethics by example in which the aim and purpose of the education was to develop an integrity of your desires that will justify other people to trust you.

And that does mean sometimes having an unbalanced evening or two. And it's that that I want to ask you, Dr. Frank. Where is the risk-taking here in the process of, as I would want for you and for me, to be generous? But "generous" now means generous at the level of the blood and bone.

PROF. FRANK: It's a very eloquent statement of a professional ideal, and who wouldn't want someone who expresses that, who embodies that, as you've said it?

There's a level at which what happens is not going to be decided by you or by me or by the Council. Life will go on, and forces will shape what happens and, in my view, contingencies will enter in that we can't imagine, and these young people will become who they become in institutions that require them to become that sort of person. And whatever either of us would like, it will happen.

The issue is — as I was reading this, I was struck again at how I was perpetually dividing things into two through my whole talk. It's the most binary-oppositional talk I've ever put together, and I think the reason for that is when I try to think seriously about these issues it always involves a balance. It always involves, well, there's this side, but then there's this side. And both sides of that balance have their demands. Both sides have some legitimacy behind them.

You've spoken very eloquently about the physician who takes risks including his or her own life. First of all, these young people often do do that. They go to third-world countries. They've often got into medical school on the basis of having taken years off doing work that was dirty work in different places. They're highly committed.

By the same token, what I hear in this notion of balanced life — and it's a researchable question. We could all hear different things depending on who we're tuned into. But what I hear is a recognition that the old heroic image is really no longer attainable and it always had its downside. The downside was the physician-as-god syndrome. The downside was medical paternalism. It was a lot of things that instigated bioethics back in the 1960s. You know, it's what got people like Paul Ramsey and Jay Katz and others to realize that there was a necessary counterbalance that had to be brought in because medicine was somewhat out of control, and we're here today in response to the, I think, quite correct perception that there were excesses of physicians who were not risking with their own lives. They were sometimes risking with other people's lives and not getting the fullest consent for the risk they were taking with other people's lives.

And so there's the heroic side and there's the dark side, and if physicians today want balance, it's not just that they want to have their own evenings with their families. It's also that I think they are looking back on certain excesses of the past, and they're seeking to avoid those.

And, unfortunately, what you said is entirely true. Every present age is a solution to the past age and it tends to throw out often some of the finest aspects of the past age in an attempt to remedy some of the excesses of that age. And to that extent, we're all on the wheel of history, and we try to hold on to what is best. Sometimes we're successful. Sometimes it gets lost for a while and has to be brought back at a future period.

What I've tried to do is the smallest way in which I can think about people recognizing the deforming influences of the institutions in which they work and holding onto the best impulses which I think were part of the challenge that was being presented to you.

It's such an ironic thing to have Beth Israel quoting the Catholic monastic tradition, but that's an example of being able to reach across and take whatever was best from the past and hold onto it, and that's what we need to do.

CHAIRMAN PELLEGRINO: Professor Schneider, this will have to be the last comment. We've used up our time. Carl?
PROF. SCHNEIDER: In the interest of having the trains run on time, I'm happy to yield back my time.

CHAIRMAN PELLEGRINO: You don't have to. You do have the floor if you wish it.

PROF. SCHNEIDER: I'm going to get it pretty soon, so I'll wait. Thanks.

CHAIRMAN PELLEGRINO: Thank you. We will reassemble at 10:30.

SESSION 2: THE HEALING PROFESSIONS/MEDICINE

CHAIRMAN PELLEGRINO: Good Thank you very much. Those of you who are here, thank you. I think we'll move ahead. The next session is a continuation of the discussion of the healing professions/medicine. We're going to be addressed by Professor John Hardt, Loyola University of Chicago.

Dr. Hardt, the floor is yours.

PROF. HARDT: Thank you, Dr. Pellegrino. Dr. Pellegrino reminded me at the break of the Council's custom of not doing extensive introductions and rehearsing lists of publications and honors, and that's a custom for which I'm tremendously grateful. Given a review of my CV, it admits of no other kind of introduction than a brief one. So it would be difficult to tell you what a privilege it is to have this invitation to be here today and I am truly grateful, and I hope that my comments can be of some help to you as a deliberate body.

I've read with interest the Council's transcripts from previous meetings during which you've discussed what has been described as the "Crisis in the Ethics and Profession of Medicine." Many of your previous distinguished guests have attended to the negative affect of market forces on the medical profession and the need for a morally enriched system of medical education to counteract that influence and bolster society's and the practitioners' perception of the profession.

My comments today steer a course at some distance from those concerns, although I am coming to think that these two topics — that is, market influences in healthcare and my topic today, conscience and its relation to the moral foundations of medicine — may very well be related in the end.

This morning, I hope to build upon Dr. Pellegrino's closing comments from your meeting of September 6 in which he recognized something of an identity crisis in medicine today. He suggested that we ought to attend to the current confusion concerning the profession's understanding of its own relationship to society, a confusion that Dr. Pellegrino suggested might be resolved, at least in part, by what he called a "reprofessionalization," a kind of reestablishment of the moral foundations of medicine that would undergird the traits that characterize "professionalism" — as he described them: competence, fidelity, and trust — with a normative moral vision of the profession itself.

I think that the recent debates concerning conscience in the clinical encounter are an important expression of this confusion about medicine's relationship to society noted by Dr. Pellegrino. I say this because I wonder if the question of conscience's role is, at its core, a question about how medicine, individually embodied in the physician, relates to society, individually embodied in the patient.

The two articles I supplied to the Council offer you some perspective on the issue of conscience in the clinical encounter and the recent attention it's been receiving, and I'm happy to return to those as you see fit in question and answer.

But my comments today are aimed at arriving at a simple conclusion that I think can be stated in two parts. First, much of the current and contentious debate over the role of physician conscience in the clinical encounter rests upon an under-attended-to but longstanding dialogue about the nature of the physician-patient relationship and, more broadly I think, what constitutes the appropriate ends of medicine. To the extent that we fail to see this, I worry that our debates about conscience in the clinical encounter will generate more heat than light, leaving us as a society more polarized and angry with one another than reasoned and willing to civilly engage each other as we search for some common ground.

Second, if we as a society — or the profession itself, as some have proposed — simply ban conscience from the clinical encounter or even prohibit persons of serious religious and moral commitments from becoming physicians, I am worried that we will cut short a much needed conversation about the ends of medicine and the future course of medicine as a social trust and a professional practice as these issues, I think, lie beneath our concerns about conscience.
To help anchor this very theoretical claim, I'd like to consider the following case: Mr. John Burke is a 54-year-old widower of three years, the father of three daughters, a professor of marketing, and a patient of Dr. Robert McMahon now for the past four years. He comes to the office today for his annual physical. His exam confirms what Dr. McMahon suspected upon Mr. Burke's presentation; namely, that Mr. Burke is a healthy man.

"Everything looks good, Jack," concludes Dr. McMahon, with a pat on the back as Mr. Burke rights himself on the exam table. "You've even lost four pounds since I saw you last. You're doing great." Reaching for his pad to write a prescription for a persistent allergy, he adds with characteristic warmth, "I wish more of my patients were like you."

Mr. Burke smiles, slides his arm into the sleeve of his shirt and begins buttoning, reluctant to interrupt the physician's pen on pad with his question. "Glad to hear it, Doc. I — there is — uh — there's one more thing I want to talk to you about."

Dr. McMahon leans against the exam room counter, rests his hands in his pockets and faces Jack, offering his full attention. "Of course, Jack. What's on your mind?" "I've begun dating again."

"That's superb news, Jack! I'm thrilled for you. While we haven't discussed it much, I can imagine how difficult Angela's death has been on you and the girls. I'm so pleased to hear that there's an opportunity for some personal happiness in your life. You deserve it."

"Thanks, Doc. She's a wonderful woman. We've been seeing each other for four months now and things are going well. But I'm having some problems with impotence — you know, ED, erectile dysfunction."

"Oh, okay. Sure. Fill me in a little bit."

Less than a minute into Mr. Burke's recounting of his experiences in the past month, Dr. McMahon mercifully relieves him of his narrative, saying, "Jack, this certainly sounds like what you think it is, and it's not at all uncommon. Know that there is nothing more serious going on here. You're healthy and have nothing to worry about. And as you probably already know, there are some options for medications out there that treat ED very successfully."

"Well, great. I mean, good then. I'm happy to hear that it's nothing serious. This isn't the easiest thing to talk about. "Please don't be embarrassed, Jack. I appreciate your trust and candor."

"So which one of these medications would you recommend," asks Mr. Burke.

A pause precedes Dr. McMahon's answer as he takes a seat on his stool. "Jack, this is awkward for me, but I can't prescribe any of these medications for you." "What do you mean? Am I not a good candidate for these drugs?" "No, you certainly are. You're just the kind of person these pharmaceutical companies would want to reach," replies Dr. McMahon.

"The problem is that I'm not the right doctor for you on this. What I mean is that, as a point of principle, I don't prescribe these drugs for men outside of a marriage. I don't mean to put you in an uncomfortable position here, Jack. And again, I really appreciate your willingness to talk to me about this. It's just something that I feel committed to in my practice—" "Are you serious Doc? I mean, are you able to refuse this? But you're my doctor!"

This case scenario above recounting a physician's claim to conscience in the clinical encounter is, in the minds of many, cause for alarm. When presenting this case to healthcare professionals, the responses I hear are predictable and often visceral. Many respondents share a common sense that this physician has in one way or another failed to fulfill the obligations of his professional role. I've heard the following and repeated: this physician has imposed his personal values on a patient, embarrassed a patient, damaged the physician-patient relationship, betrayed the patient's trust, violated the patient's autonomy, and degraded the practice of medicine by failing to meet the public's expectation of what happens in a doctor's office.

However, when the dynamic of the case slightly changes, opinions invariably follow. So, let's say, for example, that Mr. Burke is not a widow but a married man who reports the same problem with ED. In response to Dr. McMahon, saying, "Oh, I'm so sorry to hear that. It must be putting a strain on your marriage," Mr. Burke replies, "Oh no, Doc. Angela and I have not been intimate with each other in over a year. I'm having this problem with the woman I'm having an affair with. She's much younger than me, and it's really embarrassing." In this instance, many in the audience become uneasy prescribing the medication. I would suggest that this change is worth paying attention to. And I think that its significance can be revealed by thinking about the questions this case poses to our understanding of the physician-patient relationship and the ends of medicine.
The claim that Dr. McMahon has in some way violated the physician-patient relationship is telling insofar as it reveals an opinion about what that relationship should be; namely, one in which the physician is a competent, technical expert whose role is circumscribed to "providing factual, relevant information and implementing the patient's selected intervention." I've borrowed this language directly from the Emanuel's benchmark article, "Four Models of the Physician-Patient Relationship," in which they describe the "Informative Model" of that relationship. It's also been described as the "consumer" or "provider" model of the physician-patient relationship, one that stresses patient autonomy and the physician's role as a technician who restores or improves a particular capacity, system or function at the patient's request.

But were we to wholly adopt such a model of the physician-patient relationship, we'd be left in something of a bind when considering this same case with its subsequent alteration. Here, a model of the physician as technical expert, one whom assumes a stance of absolute moral neutrality, prevents the physician from a consideration of the moral seriousness of the act he's being asked to contribute to; namely, the patient's infidelity in his marriage. And, for many, this is untenable because it forces one into living a morally fragmented life.

So, in part at least, the debate about conscience raises questions about the moral life in general and the relationship between one's sense of self as a person and the various roles one embodies over the course of a day and a lifetime. I will only briefly suggest here that it seems as though a coherent understanding of the moral life requires that one carry fundamental moral commitments across role-specific boundaries, and the work of Alasdair MacIntyre and others have argued this eloquently.

While one's moral commitments may be shaped and even constrained by the role one embodies — and this is particularly important for consideration of the clinical encounter — I don't think that they can be wholly abandoned if we are to consider ourselves as good people rather than good role performers. I should remain fundamentally the same person, the same moral agent in the roles I embody as professor, father, husband, friend, and school-board member.

But here, we encounter another issue that informs a consideration both of the physician-patient relationship and the moral foundations of medicine. The idea that our actions actually shape our moral character thus influencing who we become — an insight whose roots go at least as far back as the ancient Greeks — is increasingly distant from our contemporary sense of ethics as it pertains to medicine, one predominantly shaped by a prioritization of personal autonomy over relationships and virtue.

There seems to be a growing chasm between our moral autonomy, our moral acts, and their effects on others and ourselves. Thus, the very idea of moral cooperation, the notion that participating or contributing to an action of another that one deems immoral is of serious moral concern, gains little traction in the contemporary debate.

This, too, then poses a challenge to physician conscience in the clinical encounter. In fact, when a physician refuses a particular intervention based on conscience, it is often looked upon as an act of selfishness or even aggression toward the patient. Some have suggested that physician conscience is nothing more than a weapon wielded in our culture wars, one that runs counter to the conception of the physician-patient relationship that preferences patient autonomy as the determinant both of the good to be obtained in the clinical encounter and the sole source of moral authority in the physician-patient relationship. While physicians could misuse the clinical encounter in this way, they do not necessarily do so when considering their consciences.

It seems to me that the formative force of human actions upon their agents is of particular importance to medicine insofar as the skill-set and body of knowledge physicians acquire allows them to engage, influence, restore, and enhance human capacities that are frequently laden with moral significance. This is obviously true in areas of reproduction, embodiment, and sexuality — and painfully true when physician expertise touches upon the deepest of human experiences: finitude, illness, loss, and death.

While cultural mores may have shifted away from the reverence that has at times adhered to these arenas of human experience, for some they have not. And, when we consider the case of Mr. Burke, the fact that much of the audience shifts its opinion when it becomes a question of participating in the patient's marital infidelity indicates to me that there remains something to the sense that our bodies do convey moral meaning and that we as persons are shaped by our actions. It is no accident, then, that conscience is a live issue for medicine, a practical art that bears upon the human body.

How we come to a shared conception of the physician-patient relationship is an arduous and not necessarily clear path, but I am certain that this is a critical component in understanding the debate
about conscience and the future of the profession. If the profession of medicine prohibits physicians from thinking of themselves as moral agents, inherent difficulties will present themselves to us as we try to chart a course for morally reinvigorating the profession. While conscience poses many difficult problems to us, prohibiting its presence in the clinic is not a preferable answer in my opinion.

There is much more to say about conscience, but let me just offer a quick three observations before briefly moving on to the ends of medicine. Many arguments against conscience dismiss it as a uniquely private and religious claim and, therefore, undeserving of a place in the professional encounter between physician and patient. While I don’t find arguments that dismiss religious positions outright particularly convincing, it is worth noting that insofar as conscience is the faculty of mind that determines the goodness of an action, whether secular or religious in origin, all acts that are finally determined by a moral judgment are acts of conscience. It is only those acts of conscience that run counter to contemporary mores or a widely accepted way of proceeding that get our attention.

But in the realm of medicine, we ought not to confuse the notion of an authentic, professional duty with what has become a customary way of proceeding, the latter of which one may actually have a duty to diverge from if that customary way of proceeding is judged to be immoral. And, here, we face a challenge that touches upon the ends of medicine. Medicine has customarily come to be perceived as offering services and interventions that some suggest simply are not within the purview of medicine. It is on these kinds of cases that conscience usually arises.

Second, conflicts of conscience are part and parcel of living in a morally plural world. We cannot voice support for moral pluralism while not expecting that people will actually hold to firm moral commitments that will, from time to time, conflict with another’s firm moral commitments. Thus, I think the way forward is not to try to eliminate such conflicts — the objective of banning conscience from the clinical encounter — but rather to carefully consider how best to accommodate and resolve these conflicts. It’s important to remember that patients can have positions of conscience too, and when they conflict with that of the physician, we should seek to identify a way forward that does not compromise the moral agency of either physician or patient.

The “professional” physician in my estimation will be one who can simultaneously consider the divergent values appearing in the clinical encounter, carefully consider the variety of goods at stake and the ways in which the context of the physician-patient relationship form them, and, then, prudentially determines in dialogue with the patient a way of proceeding that promotes and protects the agency of physician and patient.

Third, some have suggested that conscience will become a bastion for bigotry, idiosyncrasy and personal bias, offering something of a personal asylum to accommodate a dereliction of duty on the part of the physician. While I do understand this concern, I would not anticipate this outcome. The ends of medicine are largely shaped by the physician-patient encounter — the experience of illness of the patient, the promise to help made by the physician, and the skill set that the physician bears in aiming toward the health of the patient.

So the profession of medicine does not readily tolerate the physician who refuses to care for someone based on gender or race, for example. That constitutes a failure of duty in a way qualitatively different from the kinds of cases where conscience arises.

Second, conscience remains accountable to reason. Positions of conscience are open to public and professional scrutiny and need to fit within a comprehensible moral framework. When a conscientious objection in healthcare receive public attention, it is on those cases that exist at the margins of medicine. Now there exists a long-running debate as to whether the ends-of-medicine are socially constructed and shaped by cultural expectation or internal to the practice of medicine shaped by the experience of illness itself.

Drs. Pellegrino and Kass have been two of the leading contributors to that debate. There is little point in my rehearsing their arguments when they could do so more clearly. But let me just suggest that if, indeed, the ends of medicine are purely socially constructed — and I don’t think they are — but if they were, then our conception of the physician-patient relationship may very well meet and do little more than meet the minimal requirements established by the conception of the physician as technician who offers a service to the consumer.

The debate about conscience in the clinical encounter offers evidence that there is indeed disagreement about what the profession of medicine requires of the physician. I want to suggest that the recognition of physician conscience in the clinical encounter is necessary in order to recognize
the physician as a moral agent engaged in a practice that is morally significant, not only because of
the merciful and altruistic underpinnings of caring for the sick, but because the body itself conveys
moral meaning.

Those who argue that conscience does not belong in the clinical encounter ultimately do so based on
an argument from patient autonomy. The abuses of paternalism that led to the dominance of
autonomy are well documented, as is the swinging of the pendulum toward patient autonomy as its
corrective. It is also well-documented that, in large part, the principle of autonomy recognized and
protected the patient’s prerogative to refuse overly-aggressive medical treatments. Now patient
autonomy has increasingly come to include demands for services, services that pose a difficult
challenge to the profession of medicine insofar as their provision requires either the technical
expertise of the physician or the power of the prescription pad.

Thus, there is something of an internal conflict within medicine as it is the gatekeeper of resources
and skills, some of which its practitioners may not be comfortable using toward a body of goods that
reach beyond medicine’s response to illness and disease. And, on this point, there is a burgeoning
body of literature that examines the relationship between biotechnology and medicine, asking the
question as to whether medicine should go beyond the treatment of disease and toward the
satisfaction of various human desires that fall within reach of biotechnology.

Theologian Gerald McKenny has observed, for example, that medicine has become “a primary
discourse on the good.” Given that, one can ask whether we are narrowing our conception of the
good life to one wholly shaped by a particular vision of biological flourishing at the cost of other
human goods.

Some, indeed, have suggested that the prevention of conflicts of conscience in the clinical encounter
and a recovery of the moral foundations of medicine — would require a shared conception of
medicine that fit within a broader understanding of human health and flourishing. This amounts to
the establishment of something of a robust moral anthropology. Here, one would at least have a
common construct for ranking the various goods and obligations that medicine would serve and
fulfill. But even here one can imagine disagreement and uncertainty as to how to rank various goods
and interventions even within a shared system.

In any case, given the morally plural culture in which we reside, such a shared vision remains
somewhat illusive, which brings us back to the clinical encounter where divergent visions will meet
and for which we ought to carefully consider how to proceed.

Given that, I want to close with just a few observations about how conscience might appropriately
enter the clinical encounter. Conscience requires one to employ their moral agency wisely and in a
manner that fits the context of the interactions in which it arises. Conscience is not blind to context.
Rather, it is informed by it. As I mentioned earlier, the fundamental moral commitments of
conscience that one brings from role to role are certainly shaped and constrained by the particular
role one embodies.

So, for medicine, I think we have to particularly attend to the power differential between physician
and patient. It is critically important to preserve the patient’s dignity, to avoid embarrassing the
patient, to try to fully understand the patient’s good from the patient’s perspective, and to consider
the other goods at stake when one considers drawing upon conscience as a decisive force in the
clinical encounter.

These protections for one’s patient, it seems to me, are part and parcel of being a physician and
congregate under the promise to “do no harm.” In many of these cases, a physician’s conscience will
dictate that the physician ought to meet the request of the patient before her, despite the fact that, all
things being equal, the physician may wish the patient would choose otherwise. But this, too, is a
decision of conscience. Thus, conscience is not always an answer in the negative. But once again, it
is the refusal that garners public attention.

Being context-contingent, conscience is sensitive to the various goods at stake in the clinical
encounter. So, for example, Dr. McMahon who is reluctant to prescribe Viagra to Mr. Burke ought
also to consider the good of this particular relationship, the possibility that his refusal to prescribe
this medication could permanently fracture that relationship and perhaps negatively influence Mr.
Burke’s future health, the possibility that refusal to subscribe Viagra in this circumstance may
contribute, by word of mouth, to other patient’s fears and concerns about visiting a doctor at all.

The consideration of these contextual factors also indicates that the physician should consider both
the moral gravity of the action he or she would be participating in when making such a
determination — all acts are not morally equal. Proponents of conscience need to weigh against the false notion that one can obtain a kind of perfect, moral purity that simply does not exist in this life.

While each of us, physicians included, has an obligation to follow our respective consciences, we have also an obligation to not hide from the reality and various contingencies of our lives. There are other practical issues to discuss around questions of conscience. If the Council so chooses, I’m happy to do so. The problem posed by geographical scarcity, a possible duty to inform or refer patients for procedures and interventions, and the idea of preserving the social good of making legal medications available are all issues that remain on the table.

But I’m going to stop here, having tried to suggest why it is that conscience is both a symptom of the identity question posed by Dr. Pellegrino and, possibly, part of the solution as society and the profession of medicine continue to deliberate the right way forward.

I welcome your comments, correction, and questions, and thank you again for the opportunity.

CHAIRMAN PELLEGRINO: Thank you very much, Prof. Hardt. We’ve asked Professor Carl Schneider to open the discussion. Carl?

PROF. SCHNEIDER: Maybe I can begin with something that I think relates in some ways to this and relates as well to what Prof. Frank talked about. It’s part of my continuing program to suggest that there is no such thing as a new bioethical problem. Prof. Frank talked about the problem of there being a morally successful professional. In 1886, Justice Holmes spoke to the graduating class at Harvard about why it was a good thing to be a lawyer and concluded this way. "And now, perhaps I ought to have done. But I know that some spirit of fire will feel that his main question has not been answered. He will ask, what is all this to my soul? What have you said to show that I can reach my own spiritual possibilities through such a door as this? How can the laborious study of the dry and technical system, the greedy watch for clients and practice of shopkeepers' arts, the mannerless conflicts over often sordid interests, make out a life? Gentlemen, I admit at once that these questions are not futile, that they have often seemed to me unanswerable. And yet I believe that there is an answer. They are the same questions that meet you in any form of practical life. If a man has the soul of Sancho Panza, the world to him will be Sancho Panza's world; but if he has the soul of an idealist, he will make — I do not say find — his world ideal. Of course, the law is not the place for the artist or the poet. The law is the calling of thinkers. But to those who believe with me that not the least godlike of man's activities is the large survey of causes, that to know is not less than to feel, I say — and I say no longer with any doubt — that a man may live greatly in the law as well as elsewhere; that there as well as elsewhere his thought may find its unity in an infinite perspective; that there as well as elsewhere he may wreak himself upon life, may drink the bitter cup of heroism, may wear his heart out after the unattainable."

That leads me to the way I want to try to begin the discussion of this exceptionally interesting, lucid, thoughtful, and stimulating paper. All I want to do is talk a little bit about a parallel kind of problem in my own profession of the law.

We’ve been thinking about this problem for a really long time because, much more than doctors, lawyers identify themselves with clients and make the clients’ interests their own. One of the most famous articles on the ethical role of the lawyer is an article that describes the lawyer as a friend, a friend who almost completely identifies himself with his client and the client’s interests. And the practical sociology and psychology of law make that kind of identification almost inevitable.

Now, the trouble with that, of course, is that when you begin to take somebody’s interest as your own, you are going to be involving yourself in enterprises that you don’t always like very much. And, of course, if you were something like a criminal lawyer, you will be involving yourself in activities that nobody will like and you will know perfectly well that sometimes you will be working to get someone who should be in jail out of jail, that you will be freeing somebody to go out and do more horrible things.

The problem, of course, is that even if you say, "Well, I’m not going to be a criminal lawyer. I’m going to be another kind of lawyer," you wrap yourself and your client together and then find that your client is doing something that you cannot approve of. The trouble is that you are then so morally implicated in the relationship with your client, the client has become so reliant on you, that it’s very difficult to know what the right thing to do is.

Suppose, for example, that you are a lawyer representing someone in a divorce and you have been helping this person almost as a counselor in a very full sense. The person then announces a desire to
have custody of the children, and you have excellent reason to believe that the client would be a very poor custodian of the children; in fact, perhaps even a dangerous custodian of the children. What do you do? If you’re a lawyer representing people who want to form a company, what do you do when you begin to suspect that they are engaged in unethical, fraudulent, criminal activity? Do you go to the police and say, "Here's my client with whom I have become so involved. He looks like a pretty guilty person to me. Pack him off to jail for me"?

So the easy answer is, you’re never obliged to represent anybody. But even that easy answer turns out not to be very easy on inspection because there is a professional and generally social belief that people are entitled to representation, that people will benefit from representation.

Maybe the answer is that once you become the counselor that you are entitled to give counsel of a moral kind, and, in fact, the code of ethics specifically says, if you think your client is doing something unethical or immoral or illegal or fattening, you should say so. And the question, of course, then becomes, what do you do when your client says, "Well, that’s your opinion"?

That's a good place to stop, so let me stop.

CHAIRMAN PELLEGRINO: Thank you very much, Carl. Prof. Hardt?

PROF. HARDT: So it’s a very difficult and good question, so let me just take a stab and it, and I don't know that this is necessarily right.

It seems to me that one of the differences between law and medicine is that the legal system depends upon attorneys passionately and aggressively aligning themselves with their clients’ interests. Medicine, it seems to me, require physicians to passionately and aggressively align themselves with the restoration of health, which is a shared goal with the patient but isn’t necessarily the same as the patient’s interests. Now frequently, it will be. And there will also be some negotiation going around about what constitutes the goal of this particular encounter. So the physician may be saying, "No. You know, let’s treat this pneumonia caused by the vent," and the patient might be saying, "Enough is enough. I’ve been dealing with this condition for a decade. I’m an old woman now. The goal of health is not worth the burden it’s imposing on me to continuing to persist this way." So there would be negotiation around that common goal of health, but I don’t think that there’s that same allegiance to the patient's interest that a physician has in the physician-patient relationship.

And I’ll stop there, unless I didn’t at all address your question.

CHAIRMAN PELLEGRINO: Dr. Carson?

DR. CARSON: Thank you for that very thoughtful discussion. I thought it was spectacular, and I can’t imagine how any reasonable person could believe that you can extract conscience from a physician-patient relationship even though some might proclaim to have done so.

At the risk of throwing out an analogy — and I say a "risk" because usually when you throw out an analogy everybody starts trying to figure out ways to break it down instead of figuring out what you’re saying.

But, you know, suppose you were a gun dealer and a man who lives in the wilderness comes to you and he wants a gun and he wants it because there are wild bears and they attack people. Well, you’re probably going to want to advise him on the best type of weapon to protect himself and his family in that situation. However, if he wants it because there are criminals in the area, even though you may be quite willing to sell him a gun, you might have some other advice for him in terms of how to deal with that as opposed to shooting the criminal. If he wants it because there are certain types of people, perhaps from across the border, that he just doesn't like and he wants to kill them, then you really are going to have think seriously about whether you’re going to sell him any type of gun. And I think that would probably be a universal feeling about people.

Well, I think physicians are very much in the same situation. There are some situations where everyone would unanimously agree that you simply can’t go along with that program and others in which you can. But, you know, I think that the real key here is, one has to say, what is a real physician? What is a healthcare provider? You are there primarily to make sure you do not compromise that patient’s health and that you enhance it. But you must also make sure that you don’t compromise your integrity because then your effectiveness as a caregiver is going to be significantly impaired by your guilt.

PROF. HARDT: Nicely said.
CHAIRMAN PELLEGRINO: That’s to the point. Thank you. Anyone else? Dr. Dresser?

PROF. DRESSER: Thank you. I thought that was a very balanced presentation. I wonder if you think that the vulnerability of the patient creates any kind of a presumption in this area. And then, second, what about perhaps an educational organizational approach that would address these issues more ahead of time?

So, for example, in the '80s, we had some physicians saying, "Oh, I'm not going to operate on patients with HIV because I don't want to take the risk of being infected. That would be unethical because I have responsibilities to my family." And medical residents starting complaining that they were taking care of too many HIV patients and they weren't getting the kind of education they should. So some schools started putting in the catalog to med students, "Part of what you do will be caring for patients with HIV."

I wonder if more could be done in that area. For example, I mean, if you're thinking about going into critical-care medicine or geriatrics and you're someone who thinks one should never forego life-sustaining treatment, is that a realistic belief to have, a permissible belief to have, to go into those areas or should you go into a different area? So I wonder if you've thought about those kinds of systemic, I suppose, ways to, not eliminate conflicts, but reduce the conflicts?

PROF. HARDT: Thank you. That's also a very good question and a difficult one.

I suppose that I have a couple of concerns. One would be, I don't want us to find ourselves in a position where, for example, if you're going to be an OB/GYN, you have to agree to participate in abortion or you have to agree to refer all of your patients for preimplantation genetic diagnosis or prenatal testing to make sure that they don't give birth to a child with Down's Syndrome. And that is the concern, that what we'll do is say, "Well, if you're this type of physician, then you shouldn't practice in Arena X."

Now your case about geriatrics, let's say, and aggressive life-sustaining measures is an interesting one because that becomes a moral question, and I do ethics consultation in our hospital, and that's one that we come up against quite frequently where you'll find either a family member or a physician who thinks that participation in this particular act of removing the vent, for example, would be immoral, would be directly causing the death of the patient. Those are authentic and serious moral considerations, but I think that's of a different kind than saying, if you're opposed to Procedure X, then you shouldn't be this kind of doctor.

Now that said, you can't be a surgeon, if you're opposed to scalpels. So that goes to us kind of identifying the internal nature of the ends of medicine. There are some things that you simply can't be opposed to if you're going to be a physician. But what I would want to suggest is that in these arenas of conscience, we are pushing at those margins, at those interventions, those drugs, etcetera, that don't easily fit within a particular end. A followup?

PROF. DRESSER: Just a brief followup. I wonder what you think about duty to inform of options versus offer the procedure or whatever. Is there a difference there?

PROF. HARDT: Sure. I'd be happy to comment on that. Let me say one thing before that because originally I thought your question was going to be, do physicians have the obligation to warn patients before they enter the clinic that, "By the way, I'm this kind of doc. I don't prescribe or do A, B, C, and D"? I'd be in favor of that especially because of the power differential that you mentioned. I think it would be better to let patients opt out of that encounter and conversation to prevent embarrassment if they want to before they find themselves in it. So it would have been better if Dr. McMahon had posted in his waiting room, had handed out with the insurance form a form saying, "This is the kind of practice I hold to." That's one issue.

Regarding your followup here about referring versus informing of options — and this is somewhat off-the-cuff. I haven't completely thought through all of these issues — I think one could make an argument that a physician has an obligation to inform a patient of all options that are socially considered part of medicine today even though some of those options the physician, one, might not consider part of the ends of medicine, and, two, might be strongly morally opposed to. But I think that you really compromise a patient's moral agency if you don't give them the options that are out there whether you judge them to be morally good or morally bad.

The second comment I would make is that, on referring, here one gets deeper into this issue of moral cooperation, and I'm reluctant to say that a physician has an obligation to refer, particularly for services that the physician might consider gravely immoral. Abortion comes to mind. If you are of the opinion that this is a human life that's instilled with the full moral value of personhood, then
your writing that referral brings you fairly close to that act. Certainly many people would say that. So I'm much more reluctant there.

But laying out the options for a patient? I think there's room for that.

CHAIRMAN PELLEGRINO: Prof. George?

DR. GEORGE: Well, thank you, Dr. Hardt, for that great presentation. You have a real teacher's gift. I envy your students at the University of Chicago. They're very fortunate.

PROF. HARDT: Thank you. I'm at Loyola University.

DR. GEORGE: Loyola. Well, then, I envy them. I have two questions. Let me ask the first one and then invite you to respond, and then if I could ask the second one, I would appreciate it.

My first one is whether the conflict or difference of opinion in the profession is really between those who hold the conception of the physician or healthcare provider as a technician and those who have a different and broader view that would make more room for conscience? Is that really the division? And you can tell by my asking the question I suspect it isn't. Or is it simply a difference of opinion on the substantive moral questions?

Here's my guess. My guess is that there are a relatively small number of people in the professions who hold the technician view. They may think they do. They actually don't. And when you press them — and you've already taken one step with Dr. McMahon in radicalizing the problem when you shift to infidelity. We could easily wipe out anybody, virtually eliminate from the room anybody who would be unsympathetic to Dr. McMahon simply by further radicalizing the hypothetical case.

So I'm wondering, is the real difference just the substantive moral differences on questions like sexuality and abortion and life and death and so forth? And then, if that's the case, then it becomes a struggle within the profession as to whose moral vision is going to prevail in the practice of medicine and the health professions more broadly. And, of course, medicine itself can't answer that question internally and so it begins to look like a political question. Is what I suspect true?

PROF. HARDT: I think that it is. Thank you for the kind words, and I think that your comment is right on point. So there is another issue underlying this idea of the physician as a competent technician, and what I suspect is that when you read arguments or hear arguments that argue against conscience in the clinical encounter and may suggest that the physician's obligation may be shaped by what's legal and what the patient wants, which is essentially a description of the physician as a competent technician, that really isn't necessarily what they mean.

The issue is that that group is very comfortable from a position of conscience with the way ethics is proceeding and with the way medicine is proceeding. The ethic that's informing medicine fits their moral vision of the world, so they don't have any hang-ups about the way we're going forward. So it's easy for them to say, "No. Let's just make it what's legal and what the patient wants and make it our guide." But I do think that each of us has our hypothetical case where we would say, "Well, wait. I don't know that I wanted to go in that direction." So while some folks may not have a problem with the way we're practicing now, I imagine there are those cases and those instances where they would have that problem.

To the second part of your question, so does this just become a battle of moral visions within the world of medicine and are we going to get that critical mass of Physician A versus Physician B to tilt our vision of medicine in one way or another?

Here, I think I would defer to folks like Dr. Pellegrino and Dr. Kass who have suggested that, no, there are actually ends of medicine that are revealed to us independent of one's political leanings and that adhere around the notion of illness and health that we understand fairly commonly, and that's not to say that there wouldn't be room for debate within that, but that the experience of illness itself and the response of medicine gives us a set of fairly defined ends that constitute the practice of medicine and that remain somewhat independent of any particular vision or system.

DR. GEORGE: Thank you. My second question has to do with entry into the medical profession in particular, though for all I know it might be applicable if it's an issue at all to other parts of the healthcare profession and I frankly hope it's not an issue and that you can assure me that it's not an issue. I raise it in the following context.

Recently, Dr. Pellegrino, Dr. Hurlbut, and I were among some speakers at a conference at a small Catholic university in Ohio called the Franciscan University of Steubenville, and it was on healthcare
ethics. And at one of the panels, I was startled by the focus of the audience in asking questions, and these were mostly Catholic, but not exclusively Catholic, doctors and nurses and other healthcare professionals and their focus on what they perceived or asserted as being barriers to entry into medicine against those who have traditional religious beliefs or moral convictions or both.

Evidently — and I’m myself from a legal background, not a medical one — but evidently medical school, unlike law school, sometimes involves interviews for admission, and various members of the audience, one after another, began talking about interviews that they had experienced or that they knew about in which the prospective students were being asked questions which seemed to be trying to smoke out their religious and moral convictions in a way that they’ve thought must mask an intention to ensure that people who think perhaps the way that Dr. McMahon thinks, you know, won’t be allowed in the profession because they won’t be able to fulfill what those in power currently think doctors ought to be doing.

So this is the first I’ve ever heard of this particular problem, if it’s a problem at all, and I’m wondering if, from your perspective, there is a problem and, if there’s not a problem, what would be causing this particular group of people to think there is?

PROF. HARDT: So I can speak to this with really no authority at all. You know, I teach at a Catholic medical school. I can tell you that I have a colleague who sits on the admissions committee. We welcome students of all divergent backgrounds, religious and nonreligious alike. But we’re certainly welcoming of people with religious commitments as we think it contributes a great deal to the catholicity of our institution, which is something we care about.

Could there be the formation of kind of a subtle moral litmus test to the profession of medicine? I suppose that’s possible. I’ve never heard of it myself. Now I’m fairly new to medical education, so people senior to me may have more stories of this.

And as to what would account for these people’s experiences, I mean, I would give them the benefit of the doubt that what they say is true, although without seeing that interaction, it would be very difficult to judge what was being detected. I wish I could give you a better answer than that, but I don’t think I can.

CHAIRMAN PELLEGRINO: Further comment? Bill — Dr. Hurlbut?

DR. HURLBUT: I’m not exactly sure what my question is, but it’s something about what Robby was saying and also about what you’re saying about conscience and the way medicine today is kind of a referendum on the good.

When we did our report, "Beyond Therapy," we found it fairly hard to make a clear distinction between enhancement and therapy, although we recognize that the vast majority of medicine is clearly therapy, but increasingly there’s this edge.

But it seemed when we surveyed these various edges and their potential extensions that it had something to do with this wider, larger comprehension of what you call the good or what’s life’s purpose. And it’s caused me to think quite a bit about the historicalrelationship transculturally of the priest and the healer and how medicine has somewhat to its benefit and somewhat to its detriment moved into a separate quadrant, and yet it seems there will increasingly be divisions about this.

I mean, obviously a great deal of it flows from the fact, if you will, of our pluralism, the convergence and encounter of peoples from all over the world with a lot of cultural traditions that differ and significantly on, not just matters of spirituality, but their actual medical practice rooted in matters of spirituality. But I guess what I’m trying to get at here is the question of whether there is such a thing as a sort of spiritually-neutral medicine.

I was thinking, by the way, as you were speaking, the first mistake that — was it Dr. McMahon? Was that the name of —

PROF. HARDT: Yes.

DR. HURLBUT: Dr. McMahon, the first mistake he made, I think, was to interrupt his patient a minute into the description. He could have at least listened and let that man play out the justifications that would have followed, if my experience with patients is right.

And what I mean by that is there is still a prevailing ethos in our culture even though we’re diverse. For most people, they’re very conscious of what other people think, not just what they think
themselves. So that what may have followed is he would have started to explain to the doctor why he was in this intimate relationship. He might have said something like, "Well, I'm violating my own ideals of not being in a relationship before marriage, but I'm so lonely," or "I'm confused." Slowly, other goods may have come out into the equation. Now whether that would have changed the doctor's opinion or not — but that's a vague question. I think you know where I'm going on that.

Speaking to the relationship between — I thought one of the best things you said, by the way, was the imperfection, even it would run against the ideal. Now we in medicine deal all the time with patients who are behaving imperfectly. I mean, the whole realm of sexuality is full of that. I mean, we wouldn't turn people away because they came in with either bad practices or diseases that resulted from those. And obviously it's very true of a whole range of human behaviors, not the least of which is the evident overeating in this civilization and so forth.

And it strikes me that there's a connection between what the first speaker said and what you're saying that relates down to that vulnerability issue, that medicine encounters a lot, the inability of the patient even to do himself, him- or herself, what he knows is right.

I'll just add one little element to that. It does strike me that this is a place at which the physician has a special opportunity to both be compassionate and still uphold moral principle. And, well, it's a vague question, but talk into it.

**PROF. HARDT:** Okay. Thanks very much for the opportunity. So morality and compassion should not be polar opposites. I think those two things can go together. And I do wonder sometimes if allowing conscience in the clinical encounter is not allowing humanity in the clinical encounter. But there is something to be said for a physician being able to reveal herself as the person she is, the things she worries about, the things she cares about.

I don't want to turn the clinical encounter into a personal counseling session with your pastor though. So I do think there are boundaries there. I don't want physicians proselytizing. I don't want physicians guilting. And I think that all of those things are contrary to the ends of medicine. They fall into that admonition to do no harm.

But what I rely on then is a really prudential physician. I need a physician who is wise and careful and discerning. And how do we get those future physicians into medical school? I don't have a good answer for that. But as the speaker before said, a lot of this is about developing people with character. That's one of the things I took from Prof. Frank's comments.

Let me just try to touch on a couple of the themes, and if I forget something, please tell me. You said, "I don't know that there is a religiously- or spiritually-neutral medicine out there," and you talked about the relation of the physician and the priest. I would agree with you on that insofar as I tried to indicate in my comments. Medicine touches on profoundly deep human issues, as deep as they come. You who are physicians touch upon them. So I want you to come to that with a wisdom and appreciation of how rich and deep those goods are that you're involved in.

But it's also the case — and someone correct my medical history if I get this wrong — that part of what Hippocrates was about was setting himself aside from the priests and the witchcraft that was going on and say, "No. We are something different here," and kind of narrowing the parameters and narrowing the approach and the duties and obligations to set oneself off from that so that we don't overly blur that boundary between priest and physician. So as is the case in most things, this is an issue of balancing, I suppose.

Tell me what else you mentioned there that I missed.

**DR. HURLBUT:** Well, you've certainly hit on some very central things. Let me make a comment on what you said. I mentioned my earlier medical training. I'll do it a little more here. I noticed within two weeks of my starting medical school — they did arrange early clinical encounters for us and so forth and sometimes just privately interviewing patients — and I noticed very quickly that patients were actually going through something that I imagined was like confession for them, that I was actually being asked by the patient implicitly to be more than a physician would traditionally be. And it struck me right away that this was part of the result of the secularization of society, that there was not this other ancillary social, not service, but you know what I mean, social provision for patient's personal spiritual needs and that physicians were asked to take up the slack in that. So, well — I don't know.

**PROF. HARDT:** So I'll comment on that if you don't mind. That makes good sense to me, that the clinical encounter now becomes this intimate realm because this is one person in your life that maybe in the past there were more than that who you had almost an obligation to be forthright and
honest with, disclosing of yourself and your failures and shortcomings and that they were going to
engage you on matters of incredible significance in your life.

One of my concerns is when I do an ethics consult on a case and I talk to the physician and I'm trying
to get a sense of patient history, what his family said, what's at stake here, and they will very much
concentrate on the medical and say, "We'll get a chaplain for that stuff," so that there is this sense
that, you know, the human stuff, "We leave that to nurses. We leave that to chaplains. Let me talk
about the medical, because that's what matters."

And to the extent that physicians have narrowed their vision that way, I think that, if they have, that's
a tremendous shortcoming in professional development, and that's not to say I don't want nurses
and chaplains. I do, and they do a superb job. But the idea that the physician doesn't have to worry
himself or herself with those things strikes me as innately wrong and misguided.

So that points to the fact that, yes, a physician is a competent technical expert of the human body,
granted, but the physician is more than that. So it is something of an expanding definition I think
we need of what it is to be a doctor today.

CHAIRMAN PELLEGRINO: I would like to say a word, if I might. As you all know, I am limiting
my comments with the Council, but I'd like to respond to Robby's question, just some fact issues. I
was not at the session that Robby attended, so I didn't hear those questions, but I've heard them
[from others] many times, and I'd like to simply... without further discussion ... [answer] them.

The question is asked. I've been on the faculty of [several] medical schools in different parts of the
country, and I've been on the admissions committee fo ... those schools at some time or another. I
can assure you the question is asked.

The second issue was, does it have an effect on admission? That's very difficult to discern. Those of
you who have sat on those committees realize that there is a committee discussion. The members of
the committee are all human beings with their biases, prejudices, values, etcetera, and it's hard to
know how the information about religious disposition affects the final decision or how one evaluates
the [student] or how it shapes the dimensions of the evaluation process. But the question is
definitely asked. Students have come back and said to me, "I had to answer the following questions,"
and I know from personal experience it's [the question Dr. George poses is] asked.

... And by the way, this is not limited to Catholics. One of the premier situations I remember involved
an Orthodox Jew, a very, very Orthodox Jewish applicant who was asked whether he would come to
class on Saturday, and by his persuasion he felt he could not. There was a very strong movement not
to admit that young man. He was admitted. Some of us argued very strenuously for his presence.
We also asked about Protestants who hold a very, very strong evangelical point of view and, of
course, about Catholics.

It has been proposed in the literature that Catholics perhaps should not be entering... maternal-child
health because they cannot or will not provide the full range of reproductive services.

So we're dealing with a reality. I've committed myself in print on this, so I thought I should not
remain silent...

It is also being proposed [by some] that part of the licensure procedure should be a commitment to
doing everything that's legal... The physician either should provide it or should not get a license, [it
has been] proposed, also that if a physician does not provide what is legal that the licensure body
should be the judging group and the patient could complain to the licensing body to have licensure
removed. Again, this is not paranoia, but just a statement of fact.

And I think that the fundamental question here, the ethical and moral question is, are there any
limitations to autonomy and what are they? I think there are...

With respect to Bill, I think there is no such thing as a morally neutral person. A physician being a
person regardless of his MD or her MD degree is going to [hold to] values as well. I don't think it's
realistic at all to ask for moral neutrality. It's simply a statement of fact without necessarily arguing
a point at this time. Any others?

DR. HURLBUT: If nobody else wants to ask questions, I will continue because we have obviously a
very thoughtful guest.

CHAIRMAN PELLEGRINO: Excuse me. I'm sorry?
DR. HURLBUT: If nobody else is going to ask questions, I'll continue because we have a very thoughtful guest. So if we have other questions, I'll defer to them.

CHAIRMAN PELLEGRINO: Yes, Alfonso. Prof. Gómez-Lobo?

PROF. GÓMEZ-LOBO: Yes. My question is, since I’m not in the health professions at all, is a broader information question. From what Ed just said, I find it even more pressing, and it’s this. I read one of the papers you sent us, the one in The New England Journal of Medicine. And what I got from that paper was a sense — but maybe I didn’t read it carefully enough — a sense of a tendency to say, conscience should be limited. There is a social commitment to medicine that should not tolerate these sort of niceties which are identified mostly as issuing from religious conscience. I didn’t see your argument there, the argument that conscience is really a rational judgment on any action, I mean, before any person can deliver such — well, needs to deliver such judgments.

So I want to get a sense of where we’re heading towards because I found it very troublesome if I understood what Rebecca said that there might be, say, areas in medicine where certain people should not go in because of their convictions. I would find that extremely troublesome. So, again, this is very general. But I would like to have a sense of where we’re going in this direction.

I do know, for instances, that in Switzerland they have become very strict in requiring people who are going to be licensed, I think, in nursing to perform certain rotations in procedures that they oppose as a matter of conscience. Now that would mean abandoning what appears in this article as the notion of conscience without consequence which is what the author put there as a distinction between Mahatma Gandhi, Martin Luther King, civil disobedience, etcetera, and this new form of civil disobedience. So I would be very grateful for some comments on that.

PROF. HARDT: Sure. I’m happy to, and I’m happy to defer to Dr. Pellegrino if he wants to pick up on it.

What could I say here? So I’m worried about where we’re potentially heading also. I don’t like the idea that we could find ourselves making the absence of these commitments a requirement for licensure in a particular area. I think that would be a grave mistake and a way of mishandling what people find uncomfortable, which is moral conflict.

I mean, that’s really what we’re talking about when we’re talking about conscience. It’s two people, hopefully of good will, strongly disagreeing about something that both consider to be of some importance. And because that makes us so uncomfortable, some are suggesting that the goal is to prohibit it by simply not allowing it to ever occur, and I think that that’s a mistake.

That’s not to say that the state and the federal government doesn’t have some obligation to protect some social goods at stake here. So I think one could argue there is a social good to making legal medications available to citizens — a perfectly fine position in my mind to hold.

But does that fall upon physicians to fulfill that obligation? So does that mean that if I’m a physician with a particular commitment that would prohibit me from doing [certain] procedure [or certain] acts? Does that mean that I have to be constrained in where I practice or how I practice, or does it fall upon the government to make sure that there are other physicians, other pharmacists, in that region that would accommodate that particular request so that we can protect this social good of making legal drugs, legal interventions, available?

My question would be, who are we going to put the gate-keeping responsibility on? And I don’t like the idea of it falling on the physician for two reasons. One is that I don’t think that the issues where conscience arises are at the core of medicine as a practice, so I don’t think that a physician, when he or she decides to go to medical school is signing on for all of the things that society might be expecting them to be signing on for. I just think that that’s wrong.

Second, conscience in general. We can’t begin to work from the notion that one has an obligation to do that which he or she knows is wrong. I mean, that is ultimately what conscience is about. I mean, we have to protect that because the moral life in general depends upon that idea, that one can’t be expected to do that which she knows to be wrong.

Now Professor Charles’ comment about conscience without consequence in the article that you’re referencing, I think it’s a valuable one. I don’t know that this conscience won’t come with some consequence.

I think that the market will play this out, that a physician who chooses, let’s say, not to prescribe
birth-control, not to prescribe medication for ED, not to refer for abortion services, you know, not to ever give drugs to patients exhibiting drug-addictive behavior — pick the list — if they hold to those positions and they advertise that they hold to those positions, which I think might not be a bad idea to prevent patients from experiencing embarrassment, fear, whatever might happen in that encounter, then the market might make it difficult for them to remain in practice. It may not. But I’m not inclined to think that if physicians hold to positions of conscience that that conscience doesn’t come with some consequence. It may very well for their practice.

CHAIRMAN PELLEGRINO: Dr. McHugh?

DR. McHUGH: I also appreciate the opportunity to discuss these matters with you in your thoughtful way and your approach to them. And I’m not sure, like Bill, that I’ve got a question yet evolving here except in the position of doctors and their role that you put into your hypothetical and particularly because it deals with sexuality, and I want to comment on it in two ways.

One way is I want to tell you the history, of course, about the views about Viagra in relationship to human sexuality because it’s not as straightforward as you might think nowadays. When it first appeared, there were many people who felt that health insurance should not give people this. In fact, we were at the Johns Hopkins and the president of the University wanted to know why I thought that health insurance might pay for a few of these things. I think I was surprised. And so your hypothetical that you laid out for us — and I’m going to do just what Robby said I shouldn’t do, push the hypothetical in both directions — the one hypothetical is to say should the health insurance never pay for this because it’s got something to do with sexuality to the story that you described, number one, to the story which you described that said some of the audience said, “well, okay.” And then, of course, you push it so that if the man said, “I want the Viagra so I can perform in a pornographic film. Give it to me. I need this extra energy.” Well, almost everybody would say, “I’m out.” Okay?

PROF. HARDT: Right.

DR. McHUGH: And then so when you see that kind of thing, at least when a doctor sees that or a person particularly interested in human behavioral science, you begin to think, you know, there’s something awfully problematic about sexuality, not simply in the moral sense but in the science sense as an aspect of a drive. Sexuality is a normal drive. It’s a built-in. Some people talk about it as an instinctive drive. Much of the discussion turns about it.

But, you know, it’s a different drive than the hunger, the thirst, or the sleep drive because in those other ones, if you look at them, the scripts are built in. You know, you come — you come with them. You eat, you sleep, you drink. And, well, you become more subtle in your drinking and eating later on, but for the most part it’s still scrambling for the grub.

Sex isn’t that way at all. Human sexuality comes in relationship to the emergence of, yes, drive, but as well as a sort of sense for the first time, because it’s a paired process in most ways, a responsibility for the person on the other side, and the sense of what social scripts mean for us, and we’re still struggling, aren’t we, from the various places we come from to find out what we mean by the place of sexuality in the flourishing of our life?

And that puts the doctor in a very tough spot because — and Bill touched upon it a bit earlier — that when you realize that, you’re very unwilling to jump in too quick. You do worry about this idea that bigotry will start taking over. And then, you know, you pause and think about things.

And it does bring you up to the idea that fundamentally you would like to be able to be — you should, if you were reflexes were such — that you always were on the moral top. But in this case, in the case you’ve described and the other kinds of things, we need to perfect a better understanding of the sociology of the script of sexuality in our science. And as we begin to form our positions on this, I think we will find them open to understanding how we benefit our patients, because that’s, after all, what we’re supposed to do, benefit them, as we see more and more of the outcome’s proper relations including these places of the pharmacological thing.

So I’m not sure I have a question for you so much as an idea that, whoa, I’m just saying hold back here. We’re dealing in an arena of ignorance both in science and in society, and we have to — I’m a little nervous about proposing answers — and I don’t think you are proposing it — that would lead people to have one or another kind of posture here. But look at the pressures that are on us from the powers around.

PROF. HARDT: Okay.
DR. McHUGH: Do you have any response to that?

PROF. HARDT: I’d be happy to comment on it. Thank you very much. I think your points are very well taken.

Before I comment on those, let me go back to Dr. Gómez-Lobo’s question to me because I should reference an article that I think is very helpful for understanding how one might think about the state’s role in conscience and protecting physicians and patients alike.

Robert Vischer is a law professor at the University of St. Thomas. He wrote a wonderful article, not in the *Stanford Law Review*, but another one of Stanford’s law reviews, and the title escapes me exactly, but it was something along the line of Pharmacies, Conscience, and the Marketplace, Robert Vischer, V-I-S-C-H-E-R, and it’s a very nicely done article in my opinion.

Dr. McHugh, to come back to your points, let me just try to comment on your comments. All of them were very well made. When you press that case further to the margins, I share your unease. I have some unease about Dr. McMahon’s original response, and that’s one of the reasons why I like the case, because it causes me unease, too, and I like conscience.

At the end of the day in my opinion, this is going to come down to some moral casuistry. We’re going to be dependent on people of good judgment to try to make good decisions in the clinical encounter. And if I’m going to protect conscience which I think we have to do if we’re going to have medicine as a moral profession and if we’re going to have any substantive sense of the moral life at all, I don’t think we can do that without a notion of conscience.

If I’m going to protect that, I have to allow for the possible bad judgment, the occasional slip into bigotry, the occasional patient embarrassment. I’m not happy about that at all. I wish it were otherwise. But I don’t think that we can bend.

And then on a related point when you talk about the significance of sexuality and how so many of these issues of conscience congregate around that, I do hold to the idea that our bodies convey moral meaning, that sexual expression is morally significant.

But I also worry tremendously that many of our decisions and our commitments fall on women especially hard, and I think for that reason we have to be diligent in attending to our consciences to make sure that we are not unnecessarily imposing burdens on women when they already have been burdened with quite a bit.

DR. McHUGH: I agree with those issues, and I’m just anxious for us to understand that this arena of our work is not solved by technology and how we deal with technology. It very much relates, as you say, to what it means to us and what it means to the other person and particularly to women. The transformation of the concern for women that has come — well, to put it quite simply, one of the negative consequences of the contraceptive revolution has been the problems. Women have exchanged one set of problems for another set of problems.

I won’t develop that anymore, but it’s a very, very interesting theme for us to think about, whereas in the past it used to be theme of their vulnerability to unwanted pregnancy, now it is their vulnerability to very serious involvement with infectious disorders. It is said that — The New England Journal said that 40 percent of coeds in colleges, young women in colleges, have human papilloma virus. That’s a terrible thing for them. These women have been terribly abused. So I’m of your opinion. It’s just that I’m glad to hear you say what you say, that these are dangerous waters and that we can make errors of judgment in both ways.

CHAIRMAN PELLEGRINO: Thank you, Paul. Dr. Bloom?

DR. FOSTER: Could I just make one brief comment? I think that — I think that one of the concerns about conscience in medicine and so forth that you’ve been talking about has to do with a certain narrowness of what the conscience is involved with and particularly with issues of sex and so forth.

I would say that in the broader sense of conscience and morality — for example, the expression of human concern for other humans, of love, and things of that sort — is widely considered a plus for somebody who is applying for residency or medical school.

I interviewed a student Friday, an MD/PhD student from — I’m not — I used to chair the admissions committee. I don’t have anything to do with it, but I’m talking about residency now from Johns Hopkins. This kid was judged by one of the members, senior members, of the Hopkins faculty as the best student that he had ever known at Hopkins. He’s written 16 papers already. He goes all over...
the world to manage medicine in Africa and so forth because of human concerns, and so — he's a pharmacologist. And so I mentioned him to David Mangelsdorf who is the chairman of our Pharmacology — we have the best Pharmacology Department in the world — he's a member of the National Academy, and Al Gilman who just won the Nobel Prize was the chairman of it. It's ranked in the last five years as the best department.

And I mentioned this to David Mangelsdorf, and he wrote a long note to this student praising his conscience, that he's going to be a great scientist eventually, but considered a great plus. So we need to be careful not to narrow the definition of conscience to whether you can treat erectile dysfunction to the broader sense.

And one of the things that's happened so often is, and particularly in Catholic background, that it's seen as a narrow thing and not necessarily as an absolute thing. For example, you know, in the Holocaust Museum there's a business about a woman in World War II who saved Jews by having intercourse with a Nazi SS, you know, and so one might argue that this sin, so to speak, was cancelled by love. Kierkegaard used to say, "Love covers a multitude of sins." So I just want to be certain that we're not — at the medical school where I work, it's oftentimes mentioned by people, scientists on the admission committee, that it's a plus that somebody cares for other humans in addition to knowing science. I just want to be sure we don't narrow conscience to one aspect.

CHAIRMAN PELLEGRINO: Thank you.

PROF. HARDT: Could I just briefly comment on that, Dr. Pellegrino?

CHAIRMAN PELLEGRINO: Yes, surely.

PROF. HARDT: I couldn't agree more. And just to be very brief, it's why I wanted to articulate that, one, conscience isn't just for religious people; two, any decision that makes a moral determination of good or bad is a decision of conscience; and, three, the reason that we seem — it's those cases frequently around sexuality, reproduction, human embodiment that garner public attention, and it's the answer of conscience in the negative that garners public attention versus the student you're referencing who, when we talk about him having a fully formed and flourishing conscience, what we mean by that is this is going to be a person of compassion, wisdom, good judgment, etcetera. So I appreciate your point.

CHAIRMAN PELLEGRINO: Dr. Bloom?

DR. BLOOM: I only raise this question because the discussion seemed to be flagging when I raised my hand.

But to probe the dimensions that we've just been on, I was only on the faculty of one medical school — that was the four years I spent at Yale — and there in the second year, I had a student that I brought into my lab because he seemed like a curious scholarly person and I could see a little bit of a glint of curiosity in his eyes and showed him how to do some of the procedures I was doing. And after about a week and a half, he came back to me and said that, you know, "I really can't do animal experimentation." I said, "Well, that's fine, Dan. There's lot of people who don't do that in medicine, and I do it because that's how I think the future will be solved. But there's no reason for you to do it." And I can understand. It's messy and so forth. They are healthy animals when we start, and we make something less out of them.

But a few years later in San Diego I was debating in front of a crowd of people who did not like animal research and was astonished to find a physician on the stage opposing animal research. Now if the future of medicine is in experimentation, can a physician have an ethical aversion to having animal research be done?

CHAIRMAN PELLEGRINO: That was directed at you, Dr. Hardt.

PROF. HARDT: I wish it was directed at you.

CHAIRMAN PELLEGRINO: Well, I will certainly answer, but go ahead.

PROF. HARDT: That — I don't know enough about the question specifically to say it may be the case that that would be an inherent conflict. It may be the case that one could find a middle position that would say we aren't adequately protecting animals in such a way as to resolve people's moral concerns. But with that, I'm going to defer to an expert.

CHAIRMAN PELLEGRINO: Well, I'm not an expert. I would respond, Floyd, to that one saying,
if you have that position you can't use any of the results of animal experimentation. If you live that life, it's a real constriction.

Now I want to respond to Dan's comment as well. I certainly would not accept the notion of conscience narrowly. When I talked, those were merely statements of experience and fact in response to Robby George. My own feeling is, conscience applies to every moral act that we take [from] the narrowest and the broadest.

And without extending the discussion, I feel that the real question is, where in the order of priority of things does one's personal conscience stand with reference to another person's conscience? And I would defend the right of each person to [hold to his own] conscience unless it somehow produces harm for another person...

The real question comes up... when there was no other physician available... I think the preventive act of making known to the patient the things you will not do at the very, very outset so that they don't enter a relationship with you is an important preventative.

But nonetheless I think someone who opposes animal research should not take advantage of animal research including himself or herself. So when it comes to penicillin for meningococcemia, [for example, he may feel the source is tainted morally, so] he shouldn't be taking it...

Yes, Ben?

DR. CARSON: Just a quick and hopefully simple question. With your background in theological ethics, you might be able to come up with the answer for this. What is the difference between applying conscience and being judgmental, or is it a continuum and are they compatible?

CHAIRMAN PELLEGRINO: Our last question.

PROF. HARDT: The difference between being judgmental and applying one's conscience? I'll start by saying that I'm not a big fan of people who say we shouldn't be judgmental. We make judgments day in and day out. Any time you meet someone, you make a judgment about them. When you hear them speak, you make a judgment about them. Our life is made up of judgments.

Now we shouldn't be — our judgments shouldn't be reflective of a mean-spiritedness or a lack of consideration. They should be carefully judged. They should be considered.

So I can appreciate — I think I understand where your point is going. But I want to say that conscience and judgment technically are very similar. One is making a judgment about an action for its rightness, wrongness, goodness, badness. But when I make that judgment, I don't have to in making it diminish the person I'm making it about. And I think that that is maybe where we slip into judgment in the way that you are describing it. And it's in that diminishment that I would be worried that a physician would be operating outside of the covenant she's participating in if she's doing that.

DR. GEORGE: Ed, may I add? It's Robby.

CHAIRMAN PELLEGRINO: Oh, there you are.

DR. GEORGE: Just based on my own experience in the academic world, I think I have the answer for Ben's question. It is that when you are agreeing with me, you are exercising moral conscience. When you are disagreeing with me, you're being judgmental.

CHAIRMAN PELLEGRINO: Thank you very much. And with that, we will go to lunch and be back at 2:00 o'clock.

DR. HURLBUT: Can I just add one little comment to this, the last statement that in judging one is not denigrating the opposite view? I think we have an obligation in medicine that's not often mentioned, and that is to try to find ways forward that sustain the consciences of all of the population.

And I just want to add that at this moment in our medical scientific research, sort of, interface history, we're encountering a situation over stem-cell research where we have a huge percentage of our population that has moral qualms about the way we're proceeding, and it certainly strikes me that we would be wise to find a way forward that we didn't increase these conflicts of conscience in our society.

CHAIRMAN PELLEGRINO: Thank you, Bill.
SESSION 3: THE HEALING PROFESSIONS/MEDICINE

CHAIRMAN PELLEGRINO: It's 2:00. I'd like to ask the Council members to be seated. Thank you. Is Dr. Davis around? He gives us our legitimacy, so we'd better wait. Here we are. Oh, good. Thank you, Dan.

This afternoon we continue the discussion on the question of the profession of medicine. And we have a staff discussion paper, which I presume the Council members have read. And the discussion will focus on that, and we'll start it with the members of the Council themselves, who will be the discussants, rather than having an outside discussion on this point.

I have Dr. Daniel Foster first. Dan, is that all right that you kick off? We appreciate it.

DR. FOSTER: Okay. I don't think I have anything profound to say, but I will say several things. I read David Miller's paper, and I thought it was very well written. It has much in there about issues that could occupy Council's discussion. And I don't see anything wrong with publishing a paper like this. It's a paper. Most of the people in the field—I mean the doctors themselves and others—are not going to read a document like this. They don't have time, and they're not interested, and the few people that are interested in "professionalism" will do that.

But I thought it was very well written and brings in things like implicitly the eighty-hour education rule, which has resulted in a concept of noncontinual care of patients. I mean, the residents work until 1:00, and then they leave, so you have this sort of interrupted care, and that's something that's important, but I'm not sure we're going to do anything about it, because the evidence is pretty overwhelming they're going to cut it from eighty hours a week to sixty hours a week, and how you teach medicine in sixty hours a week, I don't know.

Ed and I talked about this today. I think the term "professionalism" is really not what we're talking about here. What I talk about in this is true physicianhood—true physicianhood—not professionalism—true physicianhood. And one of the problems we have with everything in medicine and science is trying to differentiate between what's importantly new and what is trivially new. And I have sort of a visual metaphor that I'm going to ask you to imagine, because I don't have it here.

There is an African-American sculptor who made out of a single tree a ladder that is 36 feet tall. I'll show you where you can look at its picture, because it was used by Joe Goldstein in his 2006 Lasker Award address when they were announcing the awards. But I'm going to use it in a slightly different way. So it has over a hundred steps in it. So at the bottom it's two feet on a rung, and at the top it's an inch on the rung.

And Joe was using this—and it was dedicated—it's called the Booker T. Washington Ladder. Puryear wanted to say what Booker T. Washington had to overcome to achieve what he achieved, including an honorary degree from Harvard when he was forty years old and so forth and so on. And Joe was using this ladder, which is not straight—I mean, it curves a little—a single tree—when he was talking about people who are gifted enough to win the Lasker Award and to reach to the top. But I want to use the metaphor a little differently.

We publish—I don't know what the last year was, but let's say 550,000 papers in the biomedical literature in a year. That's a little more than a paper a minute. And so the question is how do you differentiate between what's importantly new and what's trivially new? And the two-foot ladder is a sign of the trivially new.

Now, I want to say something gently, and I don't want you to consider me as a Gazzaniga here, with some sort of a blunt statement of this. But we've had several sessions on professionalism here, and I myself have not seen anything that I thought was importantly new. There are variants. But I haven't seen anything that grabbed me as importantly new. They're all nuances of what goes on. And the reason for that is that true physicianhood has been around for a long, long time and hasn't changed. The environment in which it works has changed, but it has not changed.

Paul, I was at Johns Hopkins, and they had wanted me to talk in a grand rounds there. I was invited both by the Department of Oncology and the Department of Internal Medicine. They wanted me to talk about physicianhood, and I gave a grand rounds that was entitled "On Becoming a Physician—Unchanged Since Antiquity." And when you go back through this long line of physicians over centuries, the message is the same. It's called a noble profession. And then there is the famous Maimonides prayer about what true physicians were. And it was summarized by Ed's statement last session about true physicianhood involves—and we talked about that this morning—a patient and a physician.
But the physicians don’t—true physicians don’t operate by citing papers on professionalism. All of us have a nomos, an ordering system, and it’s fueled by what Dietrich Ritschl called implicit axioms. These are little cognitive half sentences that drive what we do and don’t have to be formally called out for examination. I sometimes say, if I go into a store, I don’t have to call out a full sentence that says, "Thou shalt not steal." I mean, it’s an implicit axiom.

And all the true physicians through history that I have read about, and the current ones, operate with a set of implicit axioms that automatically tell them what to do. Now...—occasionally you’ll come to an ethical problem or something that requires expertise. But the ordinary thing is fueled by this. And as a consequence, I think that to continue to write, as many people do—I mean, that’s good for a professional job, but I don’t think it’s important to physicianhood per se, that it’s unchanged.

Now, there’s talk in the paper about hidden consciences, that physicians don’t live up to what they do, and I’m sure that there have been pirates in the system for a long time. My own impression is that the residents and students are much more positive about medicine now than they were twenty years ago, when we were in the midst of the yuppies and so forth and so on.

We just finished our residency review evaluation in the Department of Internal Medicine, and part of that is that the examiner meets with residents who are elected and poses their impression about what their training was about and what the physicians were—and it’s really quite remarkable. We haven’t had the formal report, but the visitor said the residents were very positive both about the competence and the compassion of the faculty that were attending on their things. They were not—they didn’t come across as cynical and so forth. So I think that many times in many medical schools and in many private practices, true physicians become the models that we follow.

The other thing we do is tell stories. We heard that this morning. We have a college system right now so that every medical student at Southwestern has a mentor that will be the mentor for six students for four years in medical school. The mentors are our best teachers, and each college has a master, and I’m the headmaster of the whole thing. But one of the things we’ve learned—we just started it this year—is that what they reflect to in these—we have a formal, two-hour session with them every Wednesday afternoon, with the mentor and the students. And what they relate to is stories—stories of physicianhood. And we tell stories. And I think that’s a good way to teach, in addition to living the story.

Let me just give you one example. Two Saturdays ago we had the White Coat Ceremony. Those of you who work in medical schools know that a few years ago it got to be widespread that the freshman students would put on a white coat as a symbol of true physicianhood, that they would eventually get seven or ten years from now. And I’ve been doing this at Southwestern for about seven years or something like that. But let me tell you how this works.

So I told them a white coat story. And the white coat story that I told this time went back in history, and it was the day of John Kennedy’s assassination, where he died in Parkland ospital, which is our main teaching hospital. The chief resident in surgery then was the late James Carrico, who subsequently became our Chair of Surgery. He’d been at Seattle, Washington, and was recruited back here. He had been called down with another resident to the Parkland emergency room. Parkland takes care of the medically indigent in Dallas. And he had been called down. There were two patients that needed surgery. One of them had a mechanical intestinal obstruction, and the other had a thrombotic leg with gangrene. Both needed to be operated on.

While they were in the emergency room, the word came that the President had been shot. James Carrico was the first person to see President Kennedy when he got there. He immediately started fluids and started steroids. As you remember, Kennedy had adrenal insufficiency, and he remembered it—the Parkland resident remembered that. George Thorn was desperately trying to reach Parkland to give him the—he was gone—I mean, the steroids wouldn’t help. But he was trying to say—but it had already been done. It was, as you know, to no avail, and the President died. And after his family left with Johnson and the judge, they went to Love Field to swear in Johnson as the President, and Governor Connolly was still in the operating room.

Then Carrico, the chief resident, came back down to the emergency room and took the woman, an uninsured Parkland patient, up to the operating room and operated on her. And when he was through, he went home. His white coat—he didn’t tell me this till a year before he died at the AOA—he’d never told this story before. When he went home, his coat was covered with blood, and it was a mixture of blood. It was the blood of the President of the United States and the blood of an uninsured Parkland patient. And in passing I told the first-year students, true physicians take care of the rich and the poor, the famed and the unknown, in the same way. You see, it’s a story that they get what true physicians do.
When Jim went home, he felt something in his pocket of his white coat, and what it turned out to be—he reached his hand in—it was a piece of the skull bone from the President’s head. When they had tried to move his head to see what they could do, it had apparently just fallen off and slipped into his pocket. He ate supper, and then he went into the back yard—he told me later he realized that he should’ve saved this, but he burned the white coat and buried the bone. He burned the ashes and the bone of the President of the United States. And then the next morning he put on a clean white coat, and he went back to Parkland.

And I told the students, "That’s what true physicians do. They are not defeated by defeat." He went back to what he did. So one of the best ways to illustrate is to tell stories about true physicians as well as to live that. And I think that’s much better than writing papers about it.

Now, this last thing I want to say has to do—because, as David says in his paper, there are many things that we could discuss about professionalism or true physicianhood. But my own view is—as we have a relatively short time—I mean, let’s say another couple of years or a year or year and a half—I personally don’t want to spend it on more talks and things about professionalism. We’ve had some really exciting times here: the stem cell conversations, the enhancement, the suggestion of how you might get stem cells and avoid the ethical problem. We’ve discussed transplantation, trying to get organs.

As we said last session, I personally think that it would be a stronger thing for the history of this Council to end up with a serious ethical problem. I don’t consider professionalism a serious ethical problem. And what a number of us were concerned about, including the chairman, was the issue of health care in the United States, that is to say, particularly the issue that there is a large portion of our community, our larger community, that does not get adequate health care. And I think we ought to focus on that.

All I would want to say is that if we believe that—and a number of people don’t believe that. If you’re poor and you can’t get health care, that’s just somebody else’s problem. But I think if we as a Council said for the—I wouldn’t say it this way, but for arguably the best country in the world—we have our problems—it is not ideal that a large portion of our population cannot—if you live in Dallas and you’ve got Parkland Hospital, you’re okay. But if you live in a small town, in Desolate, Texas, you don’t get—you know there’s no—I think that’s what we ought to do. Not to meddle with Congress, not to do what the Presidential candidates might be talking about this, but simply to say we think a great country ought to meet its obligations to its people in terms of health, just as we meet the obligations to protect them from terrorism and all of these other things.

So I want to end up with this: having said that I think this is an excellent paper that’s been written, it is not as important to me—and, I mean, I’m not—I think we ought to do something about this thing and end up where somebody could say of this Council they had lots of discussions, they disagreed all the way, occasionally Gazzaniga is telling us we’re crazy about things, but we started with a serious problem, and we covered several other serious ethical problems, and we’re going to end up with another ethical problem, and we believe that to be a great country, we ought to take care of the needy.

It’s not just health care. I mean, we have other problems, the homeless and all sorts of—but we ought to say that we are a country, like true physicians are, of compassion and that we want to—somebody else can figure out what to do with it. That’s not our business. All we want is to go on record as saying this is something that we feel strongly about, if we feel strongly about it. That’s all I had to say.

CHAIRMAN PELLEGRINO: Thank you very much, Dan, especially for responding to my request at the very beginning of the meeting that we ought to—and I hope the other Council members will be equally direct about which of these two—and they’re not before us in this particular meeting—we should pursue and we can make a contribution to. And thank you very much.

I'm going to ask the other discussants to speak, and then we'll throw it open to general discussion to the Council members. Our next commentator is Paul McHugh.

DR. McHUGH: Well, I, too, found the paper very interesting, and I marked off a number of places where I thought good ideas were being proposed and all. But, again, like Dan, I have concerns about writing theory about the practice of medicine, in the sense that it’s just not the way we tend to work. That’s all. What happens—again, Dan has said it in ways of story. I want to put it another way.

I want to say that medicine is one of those particular life experiences—the training in medicine—in which, through the practice, especially the practice under supervision and the practice with other
people who support you in this enterprise, that you learn a lot. You learn a lot that then some people, for the theory reasons, for good reasons, propose as the representation of what the practice means. The best kind of theory, in other words, emerges out of practice, rather than that practice is generated by the theory. If the theory is of any use, it's because it then becomes feedback to you in your practice.

You say, well, this is close to what I mean. And this gathers the frame of reference that we work under and that represents the kind of person I would like to be and that I would like a great physician like Dan to appreciate what I was doing in a particular way. We have this frame of reference. And then it sits there, modified further and developed further, as the practice and the reflections on practice from theory works out.

I'm much more interested, in other words, as to what kind of a person medicine tends to generate in such a fashion that doctors, whether they be surgeons like Ben or great physicians like Dan or psychiatrists like me, fundamentally have—oh, we can disagree on certain things—we do have a kind of way of looking at what we're doing in such a fashion that, when we disagree, we know what to refer to, to solve that disagreement, what other kinds of experiences that we've committed ourselves to in which some person could say, well, I'm not sure we're living up to that.

And so that was really the reason why this morning I was making a couple of points about what I want—what I think, really, the best physicians become like out of the experience they have of working under good supervision with other people. And I was just thinking about what they were. The first one, as I say, you ultimately have this—you take on this ability and willingness to take risks. Now, usually it's not life-threatening risks, although every morning when I come into Johns Hopkins I have the little plaque to one of the wonderful men with Walter Reed who died in proving that yellow fever was transmitted by mosquitoes. But you do take other kinds of risks—risks of time, risks of energy, risks of what you might think are your development.

Then the other thing that you get from this is the recognition of the common goods that medicine provides to the society that the expression of those common goods really—and the attempt to meet those common goods as a profession—produces an individual good for you. You're made better because you're committed to the common goods that are shared within the group.

And then I think a very important part that you learn in this process of taking care of patients and being an intern, resident, and all, is that you really develop a desire to excel but not necessarily to win. You're not doing this for—the best physicians aren't trying to get a prize doing this. They're just trying to be damn good at it. And they have their models of who's good at it. But that's what comes from this, and that depends upon an ability to question your own judgment and to be a self-questioning person. And ultimately, as I said, it's an attempt to develop that kind of integrity of your own desires that other people will trust you.

Dan's little picture of the—well, didn't win today, but I'm back at it tomorrow and coming to it—that kind of thing is part and parcel of the self-knowledge and self-development that medicine gives. I happen to think that it's—there aren't very many exercises or practices in this world that develop that kind of moral agency in individuals after you've gone through it. The great part of being a doctor and having the doctor's experience, I think, as you get through it—and it helps you in thinking about your moral agency in other responsibilities and other places.

But, like Dan, I believe that the greatest utility is to continue to talk—the useful thing is to talk about just how these kinds of achievements of moral agency, this kind of development, is worked out in practice, rather than give a large conception of what professionalism is. In that way, in a small fashion, you might begin to argue a little bit about the present changes, some of them for the better and some of them not for the better. I think that this gradual constriction of hours has a good side to it, because, as we said this morning, the technology is so much more advanced than it was when I was an intern, that I'm quite sure that the kind of exhaustion that was routine with me would make it rather difficult for me to use as good judgment as you have to do with these new machines and all.

On the other hand, I think we're really—if anybody knows anything about these residents and interns, letting them off after eighty hours in the week, you're going to ask them where they went. You're going to have to have a bed check to make sure they go to bed, because they don't go to bed. They go out and do something else, sometimes even to moonlight in another place. So in some way the search—and what I'm interested in is discussions over how various kinds of people relate to young students in this field so as to help them to gain the capacity to be doctors and in that process—rather than kind of professionalism writ large, in that process develop their characters and the like.
And so I enjoyed this, and it’s a nice little paper, but, with Dan, I’m not sure where it will fit in. As I just wrote down, "Theory is a product of practice and strives to articulate the implications built into that practice in such a fashion as to be able to reflect back on matters of practice under dispute." That’s what I think the place of theory is. And I’m sure you wouldn’t all agree on what I consider to be the aims of this, the aims of professional education. But it’s those kinds of things, practical things, that I would like to see articulated in a paper. Thank you.

CHAIRMAN PELLEGRINO: Thank you very much, Paul. Ben?

DR. CARSON: You know, I find the discussions about professionalism very interesting. And I would have to agree with Dan that nothing has really changed very much in that realm. But something has changed very significantly, and that is there are a lot more impediments to professionalism now. And they seem to be continuing to be compiled on a daily basis by a slew of self-interest groups and bureaucrats which have insinuated themselves into the doctor-patient relationship. This is actually a very serious problem.

But of much more profound importance, I think, is the whole issue of healthcare access and also the great disparities that exist within our society, for instance, in the African-American population, huge disparities, and most of us look at it with our intellectual glasses and say, yeah, that’s a shame, and then we move on. I’m not sure that responsible government should ignore such disparities, particularly if there are things that can be done about them. I think we perhaps have the ability to bring this to a level where it can no longer be ignored.

And also the whole issue of healthcare cost—when we start looking at amount of our economy that is dedicated to health care, it’s a staggering amount of money. It’s far more than enough money for everybody to have excellent care, and yet everyone does not get excellent care because of the enormous amount of abuse and waste that we simply wink at and tolerate and don’t really have the courage to attack those entities which are wasting the people’s money. So that would be my comment on this.

CHAIRMAN PELLEGRINO: Thank you very much, Ben. I’d like to open the question now to the members of the Council. And this is an important point: please express your thoughts about whether we should or should not proceed further on this particular topic. So I see a hand.

DR. BLOOM: Well, just to get all of the medical points of view on the table at one time, I’m in full agreement with Dan’s desire that we concentrate on the subject we’ll talk about tomorrow, which is the problems with the current healthcare system. But it strikes me that there are many aspects of the points described in the Miller paper that could be brought into that broader discussion on the current concerns, including what Ben just mentioned about disparity in health care.

I’m reminded of Dr. Leach’s comment when we met the last time, that we’ve grown to tolerate these constraints, and it’s not far away from the anecdote our speaker this morning talked about—getting on your rocket ship and going to another planet and then ignoring everything that happens there because it’s not real. I mean, we know that the current situation is bad and growing worse and more costly, and yet we tolerate it, and we have to stop tolerating it.

CHAIRMAN PELLEGRINO: Thank you very much, Floyd. Bobby?

PROF. GEORGE: Yes, thanks, Ed. I just wanted to follow up something that Ben said and ask Ben some questions, because I think this is the first time at least I’ve heard the access issue discussed in terms of problems of waste, fraud, and abuse. And I think if Ben’s right there, then that’s a very important connection that’s got to be explored. And so Ben, if I may ask, to explore that question properly, would that have to be done at the retail level, or could it be done at the wholesale level? In other words, would it have to be done with a kind of Grace Commission type operation that examines each institutional provider of health care, or could anything useful be done—I’m not saying by this Council, but by a Grace Commission type inquiry into the general problem, if it’s one that transcends many institutions, to see if there were guidelines that could be formulated that would at least minimize to the extent possible—I realize you cannot drive waste, fraud, and abuse completely out of anything—but minimize, to the extent possible, waste, fraud, and abuse, especially as it bears on access.

DR. CARSON: Well, I would not claim to have all wisdom in this area; however, I don’t think that it takes a great deal of analysis to recognize that when we are taking so much of the healthcare dollar and paying entities that don’t need to be there in order for good health care to occur, that act, in and of itself, deprives many people of the health care that they should be getting.

What do you need for good health care? You need a patient and you need a healthcare provider.
Now we've created an entity to facilitate that health care which is much bigger than the patient or the healthcare provider and which sucks the life out of the system. I don't see why we need a Grace Commission to make that point. I think people who talk about this tend to be personae non grata sometimes, but the fact of the matter is, if we don't talk about it, our system will continue to deteriorate, particularly as the population gets older, and more and more people need health care, and fewer and fewer people have access to it.

PROF. GEORGE: If I could follow up with Ben, is a significant part of the problem regulations by various levels of government that result, by the law of unintended consequences, in unproductive uses of resources, and then, second and parallel to that, to what extent is the problem needing to meet the demands of insurers and the overall insurance system? I'm wondering to what extent the problems are there and not actually in the institutions just as such themselves.

DR. CARSON: Well, you're hitting at the crux of the matter here, because—and, again, I'll keep harping on the same topic, because—a good healthcare provider and a patient—and what we've done is we've insinuated all of these regulators into that relationship with the proclamation that they have a much better and saner approach to health care than your physician would have. And I think there's the rub. And what we really, in my opinion, should be looking for are ways to reduce the cost—and it comes back down to a cost issue when it comes to access—reduce the cost to a level where people can afford their own health care. And then, very much like they do in Scandinavia, it would not then be unreasonable to require that people own healthcare insurance.

It is unreasonable at this stage, because the cost is way over-inflated. It doesn’t need to be anywhere near that high if we get these unnecessary entities out of the way. And I do believe that those interfere. The desire of hospitals now, the desire of physicians to get an A from all of these regulators, so that they can be “the good people and the best people”—this is ridiculous, and this doesn’t have anything to do with good health care. People will know themselves when they’re getting good health care. And market forces will lead them to people who provide that good health care if we remove all the impediments from the way.

CHAIRMAN PELLEGRINO: Dr. Gazzaniga?

DR. GAZZANIGA: Well, I’m Mr. Blunt here, I guess. I’ve come from a medical family. I have a father who is a physician, went to Loyola. My sister went to Loyola. My brother went to Dartmouth. My two nephews went to Dartmouth Medical School. And all of them—all five of them—have a stance, and their stance is that their moral stance is not what the patient is interested in. The patient is interested in medical service. And the physicians are the ones licensed to provide it. And when you go to see a doctor, you really don’t care about their moral stance. You want their best medical thinking on how to deal with your problem.

And it seems to me that that is a fundamental part of this equation that we’ve been talking about: the moral stance of the physician. Well, there's the moral stance of the patient, too. The patient's moral stance is I want intellectually bright and current service. You are the provider. Provide it.

But, having said all that, that's not what we're about here on this Council, as far as I can see. If we go back to our original charge, we are to deal with the biotechnological developments that impact the public. And it doesn’t strike me as how you’re going to handle the profession of medicine as one of those. What is relevant is this other issue that keeps popping up and I just want to put my two cents in on supporting. Certainly biotechnical developments are going to allow for genotyping of everybody fairly soon, and it's already done, but on a mass basis, and so everybody—everything is going to kind of be known. The risks of people are going to be known. They won't be private; they'll be known.

And once we move towards what’s known about us, where the devils lurk in our future, it just follows that we need single-payer health care, but one can’t imagine any other system. I in my own family have a niece who I know will need a $40,000 biochemical treatment every year for the rest of her life because of a certain thing she has, and how else can that be provided other than by a system that says we're going to provide it? You can't hang onto the parents' insurance past the age of 23 and so forth. We all know the problems.

So, anyway, it is such a clear issue, and you can come at it now politically and socially and morally and all these other questions, but the fact that's coming down the pike from the biotechnology community is we're going to know everything about you and where you're probably—what you're going to probably die of. And that being known, you can't let that fall into the private insurer's hands, who can eliminate you from coverage. So we've got to go to some kind of single-payer system. We've got to have a system that says we're going to care for each other. How we do it, I have
no idea. That’s another issue. But that we have to do it seems to be clear. And I think that’s what we should concentrate on.

CHAIRMAN PELLEGRINO: Thank you very much, Mike.

DR. HURLBUT: Mike, I want to understand what you’re saying exactly, because it strikes me as very important. You’re saying that once we have the capacity to individually, personally discern the genetic sequence of every patient, either the whole thing or the salient markers, that we will then be able to predict their medical future, so to speak, their history in advance?

DR. GAZZANIGA: We will be able to predict all kinds of things about the probabilities of contracting certain diseases. That’s where it’s all going. And so if you have a certain allele situation, you’re going to obviously—this is all knowledge that’s unfolding now. I’m not saying I have a book here. But there are things that are known—that that’s going to just be very telling about your future health probabilities. And once you have that—disease probabilities. Once you have that, people are going to steer away from you if you have this sort of genotype versus that, and that kind of problem I see as coming down the pike.

DR. HURLBUT: Well, I want to understand what you’re saying, because in fact the medical outcomes will be the same as when we didn’t have that information, except where we can intervene—

DR. GAZZANIGA: Well, when you’re going to take someone on to insure them.

DR. HURLBUT: Well, that’s what I’m asking. Is this what you’re saying is that it’ll throw the whole issue of insurance into disruption?

DR. GAZZANIGA: Yeah, I think so.

DR. HURLBUT: So—

DR. GAZZANIGA: It’s just a prediction, but I can’t see—under the current system there’s all kinds of ways people are being excluded from medical insurance now, so it would only compound the situation. Correct me if I’m wrong, but that’s how I see it.

DR. HURLBUT: Well, I mean, I do—I’m not the one to correct you, but I do have some doubts about the ability of our genomics to predict so specifically such a large amount of data as you’re implying. But be that as it may, I don’t doubt that there will be proclivities and statistical data correlated with genes. The informatics of that will be so complicated, it’ll take generations to correlate it. You have cases where you have even identical twins with quite different medical outcomes, even for things with single nucleotide differences. So obviously the equation is not simply your genetic heritage; it’s your environmental encounters and a lot of stochastic events, and it’s going to be very complicated. So we shouldn’t overimply on the record here that genetics is determinative.

But your point isn’t really that, is it? It’s just that you’re saying that with a lot of information and maybe even misinterpretation of that information, in the sense that it’s more determinative than it ought to be—interpreted as more determinative—that there’s going to be a discriminatory—or a parsing, if you will, of patient populations with insurance. That’s what you’re getting at, if I understand.

DR. GAZZANIGA: Yes. And on the former point, that it will be a complex science full of tremendous charges to the field of informatics, that’s absolutely true. But help’s on the way. My daughter is a graduate student in genetics, and I think she’s going to whip this one out.

CHAIRMAN PELLEGRINO: Other comments?

DR. FOSTER: Could I just respond to that thing very quickly?

CHAIRMAN PELLEGRINO: Yes.

DR. FOSTER: We already know, for example, that there are DNA repairase genes that predispose to familial cancer, and you have to—the third leading cause of death is now pancreatic carcinoma. The Johns Hopkins has the single center that I know about that follows familial pancreatic cancer, and what they do is they take secretions from the pancreas, look for biomarkers and so forth. I mean, we’re not going to solve all of these things.

But already, I mean, there are many genetic things that require ongoing testing if you want to try to save your children’s life or things of that sort from the thing, and they’re all expensive, and you’re
If you get knocked out because you have had familial breast cancer, nobody in your family can get insured again—we already see that, as Mike was saying. It’s probably against the law, but we still see it.

And we’ve said this before—I mean, the insurance companies also have to—if they know that they’re going to cover a lot of people with high risks, then there’s no way that the premiums are not going to go up. I mean, you have to solve that. Now, there are several other approaches you could take. I mean, you could stop marginalization, things for marginalization, that is, doing whole-body scans and to live two months longer for colon cancer at $100,000 a year—you can do that, or you can take the Oregon view and say we’re only going to treat certain common diseases. I mean, the solutions are not there. But I think that what we’re trying to discuss here is whether this is something that we as a Council ought to do. That’s the last thing I’m going to say.

CHAIRMAN PELLEGRINO: Thank you, Dan.

PROF. SCHNEIDER: I have more thoughts about this than I have been able to straighten out, but let me just say a couple of things. First, I would be truly tickled pink if the kinds of ideas that Ed laid out last time could somehow be put into practice in medicine. And I agree with Dan that the kinds of ideals that Ed is talking about have been enunciated, often less effectively, for a long time. And so the question in my mind becomes whether there is anything you can actually do to make doctors more like the kind of doctor that Ed describes.

I think that there is something to be said about the current—or at least one of the current favored solutions, which is, as usual, to say to the school, well, if you’d just educate people better, all will be well. I think there is an awful lot of silly thinking about what is going to be taught and how it is going to be taught in medical schools. And as I said before, I think no matter how magnificently you teach these kinds of things in medical schools, if doctors get out into the world in which they practice and find that what they were taught in medical schools is disadvantageous, dysfunctional, damaging to them, they will behave differently.

This leads me to wonder how you do—if education doesn’t work, how you do reach the world that Ed describes. And we really haven’t said anything about that, I think. Let me say a word in favor of bureaucracy and regulation. First of all, bureaucracy is here because that is the only way that you can organize large-scale human enterprises. Durkheim and Weber were cited this morning. Dukheim and Weber said this a long time ago, and every year it gets truer.

So it seems to me that the real question here is not how wicked bureaucracies are; it’s how do you make bureaucracies function effectively in the ways that you want. I think an awful lot of the actual ethical problems that young doctors and young lawyers, for that matter, have aren’t so much with doctor-patient relationship or lawyer-client relationships. It’s how to work in the bureaucracy in which they inevitably find themselves.

The next question I would ask is why do we have all of this regulation and all of the other things that we have often heard get in the way of the practice of medicine, and I think the short, short answer is because things have gone wrong. And the regulation and the bureaucracy are directed to trying to deal with those sorts of problems, and it’s very difficult to make bureaucracies work the way you want to, and it’s very difficult to make people change their behavior when they have lots of reasons for the way they’re behaving.

So I think that a really serious look at the professionalism question would lead you to be looking at those kinds of issues. And I’m not sure how practical that is. I think it might be possible to say something about the role that organized medicine has had in dealing with these kinds of problems, a role that seems to me to have been very disappointing in failing to address the kinds of problems we’ve been talking about in the kinds of ways that I’ve been suggesting, and then this leads me to my second point, and that is to agree with what several other people have said.

For the record, the figures that were cited earlier, the current estimate is 46 million people are uninsured, and that is in some way a misleading figure, because a lot of those people don’t especially need insurance. But the trouble is that a lot of other people are underinsured very significantly, and they are often in much worse shape than people who are uninsured altogether.

The other figure that we were looking for was that currently about 16 percent of the gross domestic product is devoted to medicine—health care—far more than any other industrialized country, with no evidence of any better care. And it seems to me that this is a topic worth pursuing, not because there’s anything very new or interesting to say about it—I mean, these issues have been gone over at least since Harry Truman was President and proposed a solution to this kind of problem.
But it seems to me to be wrong for an organization asked to think about bioethical issues not to at least draw the country's attention once again to the extraordinary urgency of the problem of access to health care. And also speaking as a bioethicist, I think it would be a salutary thing for the field of bioethics to be reminded that there are issues besides the one or two or three that they're interested in, and that a lot of those issues are far more important than the issues they're interested in, and the most important of these is access to good health care.

CHAIRMAN PELLEGRINO: Thank you very much, Carl. Further questions, comments? Dr. Dresser?

PROF. DRESSER: To be very concrete, is there a need to set priorities? That is, is there a sense that we would not be able to do reports on both the working paper today and the working paper tomorrow?

CHAIRMAN PELLEGRINO: Just an offhand response, and don’t hold me too strictly to it—I think we could in the time remaining do something on both, if that’s your wish. I would like to know where are they and where we would move from. But I think we could do both, if that’s the wish of the Council.

PROF. DRESSER: Well, I agree that first priority should be tomorrow’s topic. If we do something on this topic, I would hope that it would be more focused on perhaps stories and cases as illustrations. If this is directed to the public and perhaps some clinicians, I think a way to reach them is through examples and compelling stories such as the ones that we’ve heard—how to be good clinicians in today’s climate—and use that to reach any abstract principles and so forth as Paul has said. I think that would be much more likely to reach the audience and more interesting for us.

And I also, though, agree with Carl about the role of medical organizations and possible contributions that could be made in that way that haven’t been made. So I would be interested in pursuing that part of it as well.

CHAIRMAN PELLEGRINO: Thank you, Rebecca. Let me say in my answer to your question, there’s nothing to suggest that the two subjects are mutually exclusionary, so that we could conceivably discuss one background or the other.

PROF. DRESSER: Yes, I agree.

CHAIRMAN PELLEGRINO: And I think there are connections that I could think about. So let’s not exclude that possibility.

PROF. SCHNEIDER: Just one small observation—I wonder what this question would look like if we thought about it not from our point of view but from the point of view of the average patient in the United States.

CHAIRMAN PELLEGRINO: It’s one of the things you’d have to look at in the whole story. I mean, I wouldn’t want to answer that offhand, yes or no, but—

PROF. SCHNEIDER: It’s always seemed odd to me that we sit around defining the agenda of groups like this and of scholarly enterprises like bioethics mostly in terms of how intellectually stimulating we find them, and I’ve often wondered how we would explain ourselves if a panel of patients asked us what we were doing with our time to help them.

CHAIRMAN PELLEGRINO: Peter?

PROF. LAWLER: All right. Surely both topics are important. This professionalization thing seems to me to be a little bit generic. I’m not convinced it’s specific to the medical field in particular. According to the great theorist Karl Marx, the bad thing about capitalism—and there are many good things, like conquering scarcity—but the bad thing about capitalism is everyone is reduced to a wage slave. And so that means it’s not so much professionalism is threatened, but as Paul and Dan remind us every day with their words and their example, the nobility of professions is threatened, the sacredness. As Marx says, our halos are ripped off.

But the cause of this, it seems to me not to be well—although this is a very fine paper in many ways—the cause just seems a little bit muddled. So on page 11 near the bottom—five lines from the bottom—“can or should”—and, of course, the “or should” is rhetorical, because surely you should resist all these bad things—“can or should medicine resist the great contemporary American ethos of individualism, commercialism, scientism, technologism, entrepreneurialism, marketization, bureaucratization, proletarianization”—which seems to me a bit extreme, really—the great mass of
unwashed MDs who get paid—and I know your salaries are going down, but you're getting a little more than subsistence even now. And also these things—the entrepreneurialism and bureaucratization are opposites, all right? The entrepreneur doesn't like bureaucracies.

And it's not clear to me whether the threat to professionalism is the market eating up everything or bad regulations of a certain kind, too much government involvement of the wrong kind, because managed care is not entrepreneurial care. Even Ben said that if we could free these guys up some, then consumers would pick the best doctors again and all that. So the problem to me—and I'm not an M.D. and I don't really know what the threats are, and I don't even know what "professionalism"—well, that doesn't mean I don't do a good job, but the very word "professionalism" eludes me. At the end of the day, I'm not sure we have focused this thing that well on what a profession is.

For example, this morning we had this big dispute between Paul and a really fine speaker, who wanted the well-balanced life versus the noble, heroic risk-taker. And the man said the age of the heroic doctor is over. But that couldn't possibly be really true, because it's not the—so the heroic doctor is not replaced by the proletarian doctor; he is replaced by the well-balanced, bourgeois, bohemian doctor. And I think the heroic doctors will continue to emerge. I think the threat is exaggerated. I am absolutely certain things are all messed up, partly because of market forces and partly because of really bad regulations, and we're spending way too much money for way too little. I mean, all these things are clear to me. I don't have the technical expertise to fix them. But of the two topics, I think the one tomorrow is the one we should consider more taking on, or we're going to have to work on what this professionalism issue is with greater focus.

CHAIRMAN PELLEGRINO: Thank you very much, Peter, and particularly for the clarity of your suggestion and your decision and priorities, or recommendation.

Alfonso?

PROF. GÓMEZ-LOBO: This is just a personal reflection, and it's very much determined by my own limitations. I must confess that the issue of professionalism is something that escapes me in many ways. In fact, I tend to see it like Peter. I see that there are these enormous forces gravitating not only on the medical profession but on other professions, so that I just don't see at the moment a reasonable way to tackle this as a problem in ethics. I don't think it's a problem of good will. I'm not sure that certain forms of reforms of medical education would do it. I'm with Carl on that. I think it's just a problem of enormous, enormous complexity for a Council like this one.

On the other hand, I do think that there's a clear ethical problem on the other issue, and it's not just because a great country should do it, it's because any country should do it. In other words, there is something really, really ethically unacceptable in having 46 million people without insurance and therefore with limited access, because of that, to health care. It seems to me that's very important. And I wanted to side with Mike, for once, on that issue. It seems to me that you're absolutely on the right track. Why? Because if I put myself in the shoes of a businessman who has an insurance company, the first thing I would do would be to try to find as much information as I can to get rid of those people who have even minimal risk. I mean, not that we know everything that's going to happen to them, but if I could purchase somewhere a list of the people who are prone to have certain illnesses, oh, I would get rid of those the very first. Just as if I had an insurance company that insured automobiles, the first thing I would do is get rid of the bad drivers, so I would get rid of most teenagers, for instance, or charge them double or something like that.

And we're—now, Nick is probably going to correct me on this, but it seems to me part of common sense today that things like medical insurance simply, simply should be part of the communal enterprise. It should be part of the community. It's what the Scandinavians do. It's what the Europeans do. I've been told that some of their systems are not great. Fine. But the system is there. Now, summarizing, then, I'm very much in favor not of going into the nitty-gritty questions of how you design health insurance, but to put in front of the American people the urgency—the moral urgency of solving this very basic problem in the United States today.

CHAIRMAN PELLEGRINO: Thank you very much, Alfonso. Just for clarity on a few things I've said—I share the distaste for the term "professionalism" that some of my colleagues have mentioned. None of what I said at the last meeting, in my view, would be a defense of professionalism. I find the term abhorrent. My own interests are somewhat different. To look at what are the moral foundations of a profession is an entirely different question.

The second point that you made, Alfonso—I think others have made, too—I'd certainly like to say that I don't think it's impossible for us, as the kind of group we are, to ask the question: Is there a moral
or ethical obligation, and not get into the business of how you do it? That's a terribly complicated issue, which we all know is a matter of public debate right now, and we don't need another group diddling with the system. But we do need someone saying we have a [moral] obligation [as a nation] to address this problem of equity or however you want to put it.

I'm not trying to phrase the question so it comes out in a particular way. But the fundamental question is: What kind of society do we want to be? And that's a much bigger question than how you diddle with the system... Nick, I have you on the list.

DR. EBERSTADT: Thank you, Ed. First I want to warn Alfonso, if you only charge the teenagers twice as much as everybody else, your insurance company is going to be out of business really soon. I wanted to say a word about the question of medical costs and the historically unprecedented level of GDP that our healthcare system absorbs at the moment. And I wanted to offer just a word of caution about that. I don't want to be a cheerleader for waste, fraud, and abuse, but I want to suggest that even if it were somehow miraculously possible to eliminate all waste, fraud, and abuse from the U.S. healthcare system, we would very likely see an unprecedentedly high share of economic resources going to the healthcare system and only further increases in shares likely on the horizon, because shares of GDP have to add up to 100 percent, and if we look at what's happened in the United States over the last forty or fifty years, one of the big things that we've seen has been a steadily declining share of consumer resources allocated to food.

Back in 1960 about a quarter of consumer spending was devoted to food. Today it's less than half that, maybe around 12 or 13 percent. And everything has to add up to 100 percent. We've seen the share of GDP devoted to vacations and travel triple or quadruple over the past two generations. We don't see that as a crisis, because we think that the consumers are deriving some sort of benefit from their selections in these areas. Similarly we've seen a great increase in the proportion of the GDP that goes to investment over the last century. We don't see the doubling of use of output for investment as a crisis, even though there's probably a lot of waste, fraud, and abuse in what we call investment as well. In principle, investment stands to advance the economic good and the common weal.

With the United States in particular we have such an intensity in the use of new technologies in our medical and healthcare system, that it might not be surprising, even in the absence of waste, fraud, and abuse, to see healthcare costs somewhat higher in the U.S. than in some other affluent societies. We all know how expensive and clunky little calculators were at first and how the prices tended to come down when they became more routinized. There may be some analogies to certain parts of our healthcare services.

In short, even if it were possible to radically reduce or restrict waste, fraud, and abuse, my guess would be that over the decades ahead we might still end up seeing health care absorb a higher and higher fraction of total economic output, and that wouldn't necessarily require services of the Inspector General. Thank you.

CHAIRMAN PELLEGRINO: Thank you very much. Diana?

PROF. SCHAUB: I'll say something about my reaction to the doctoring topic and leave a comment for health care for tomorrow. I very much like Dan's phrase, "true physicianship," and that seems to me an interesting topic. I would like to know what it means to be a true physician in the same way that I'm interested in knowing what it means to be a true teacher. So I do think there are things there worth exploring—the moral foundations of doctoring and whether and how those are being eroded. But the fact that all of the doctors who have spoken on this topic are dubious or have some reservations about pursuing it makes me also doubtful that we should go forward with it.

So I do have a kind of suggestion. I mean, maybe instead of a report we could send our storytelling doctors on the road. I very much like Dan's phrase, "true physicianship," and that seems to me an interesting topic. I would like to know what it means to be a true physician in the same way that I'm interested in knowing what it means to be a true teacher. So I do think there are things there worth exploring—the moral foundations of doctoring and whether and how those are being eroded. But the fact that all of the doctors who have spoken on this topic are dubious or have some reservations about pursuing it makes me also doubtful that we should go forward with it.

CHAIRMAN PELLEGRINO: Thank you. That's an excellent suggestion, Diana. Rebecca?

PROF. DRESSER: I also think that's a wonderful idea, but I would say let's include nurses and other people involved in caring for patients.
CHAIRMAN PELLEGRINO: Mike?

DR. GAZZANIGA: A couple of questions for others to answer, because I don't know the answer. Why is health care, covering the uninsured, a political question? I've just never understood that. And secondly, given we're all going to be happily covered someday, it's already going on that there's a whole class of physicians who won't take Medicare reimbursement. They don't want to deal with it. So while we're working to get people covered, is there within the profession a separation effect occurring that the doctors won't take the money and the so-called—the insured will not be covered? I don't know the answer to either one, but I think they're interesting issues.

CHAIRMAN PELLEGRINO: Dan?

DR. FOSTER: Just in response—you know, you go to jail if you let somebody pay additional money if you're covered by Medicare, and you have to be covered—even Ross Perot is covered by Medicare, because he might need it some day. But if there's a procedure—I mean, this is just—I shouldn't talk about it—but if there's a procedure, and the doctors can't get paid for it, they cannot be paid to do it from private funds, from a savings account or whatever, which would then probably help people—it's in every big city, as Relman said. It certainly is true in Dallas. You cannot get—the only place that's taking Medicare in Dallas is the medical school. We had one cardiologist close his practice, and there were 1,500 people with Medicare who couldn't get care, and we had to take them. It's devastating to our group practice as well. I mean, my patients have Medicare.

You wouldn't believe—I mean, if we take our two dogs to the veterinarian just to get shots and bathed, it's $250 cash up front. I see a patient, and I'm a pretty well-known physician, and I get $43.00, and I don't take ten minutes to see them. I go ahead and see it, because I work on a salary. So there are a lot of things that you have to do. But when you get to be Medicare age, which I hope will be a little bit longer than this, it's big time.

And further, let me tell you one other thing, because I have a son who is a general internist, and his income has gone down every year for four years. He's a general internist, and he's voted the most popular general internist at Baylor hospital and so forth. Nobody goes into general internal medicine anymore. We graduate 55 residents every year, and all of them are going into subspecialties where there are procedures that you can—you know, you do colonoscopies, you'll do fine. Do chemotherapy—but if you just have brains to see it, you get nothing. And so we had—I think we had five people out of 50 or 55 this year that are going to go into general internal medicine.

So everybody's going to be a family practitioner instead of an internist. Maybe that's good, maybe that's bad, but that's another problem. It's not just Medicare, because it's the total things that go on.

CHAIRMAN PELLEGRINO: Ben?

DR. CARSON: But what Dan just described is an example of what I was talking about before when I talked about it's not so much professionalism as it is the impediments to practicing in a professional manner that has become extraordinarily discouraging. I remember a case last year of a little baby from Louisiana who had a very, very complex problem, was a Medicaid baby, and I wanted to take care of the patient. We managed to raise some funds, because it was going to require lots of different services, more so than just neurosurgery, and only to be told that, as you mentioned, because the baby was in a government program, that it would not be possible to utilize those funds to take care of that child.

You know, these are ridiculous things. And I'm not sure that that was really the intention, quite frankly, when many of these programs and these bureaucracies were put in place. Obviously it was done with good intentions, but the problem with bureaucracies and government programs is, when they've outlived their usefulness, nobody ever gets rid of them, so they continue to exact large amounts of money while they're not really doing anything except creating problems.

And I'm not saying that all bureaucracy is bad and that all regulation is bad; I'm just saying that a lot of it is, and some of it needs to be dealt with, and we need to update things, because there's a lot of progress being made in medicine—you know, we're learning new things, the genome project—all these things are coming along. They're new. We need to update the systems along with the things as they come and not just add new ones to it, which costs even more money.

SESSION 4: THE ETHICAL FOUNDATIONS OF HEALTH CARE

CHAIRMAN PELLEGRINO: We move on now to our next speaker, Regina Herzlinger, who is at the Harvard Business School—Professor Regina Herzlinger—who will discuss the ethical foundations of health care this fourth session, and a discussion will be led later by Nick Eberstadt, Council
PROF. HERZLINGER: Thank you so much. I'm thrilled to be here. I am tethered to this computer, so, as you know, when you deal with technology, it is the master, not you, so I have to be up here at the podium.

So, Dr. Pellegrino, I’m so thrilled to be here. Thank you for inviting me. And Dan Davis wrote to me, and he said, “Are there competing diagnoses of what’s wrong? What is your diagnosis? How does it differ from other diagnoses? How would you propose to treat the problem or problems? And how does your recommended therapy compare to others?” So I have come prepared to answer those questions to the best of my ability and perhaps answer some of the questions that I heard you discussing while I was waiting here. I hope you’ll find it useful.

Here is a shameless plug for my new book, *Who Killed Health Care*, which, improbably enough, has wound up on Oprah’s list, so just shows the—it has nothing to do with my book, but shows the intense interest in this subject. So what are the problems with the healthcare system? So one way of encapsulating these problems is that it’s a bad value for the money.

This statistic is just staggering, and we have this statistic over and over again. We had such a brouhaha about lead paint in toys that were imported from China, but somehow we seem almost inured to this horrifying piece of data. We also have a major economic problem because of our healthcare system. We spend roughly 2.2 trillion dollars on health care. That money is our money. It’s not anybody else’s money. It’s money that comes from taxes, and it’s money—if you receive insurance from your employer, your employer is not doing you a favor. You’ve made a tacit arrangement with your employer to be paid in health insurance rather than salary. And I will explain why you might not want to make that arrangement.

On the face of it, it’s absurd. Would you want your employer to buy your house, to buy your car, to buy your clothes? You would not, because your employer has no idea of what you want or what you consider value for the money. But because of a tax anomaly that occurred after World War II, employers can use pretax income to purchase health insurance, whereas if they cashed us out—in other words, if Harvard University gave me back the ten or fifteen thousand dollars that it takes from my salary and uses to buy health insurance—half my salary—that’s a joke. Professors are better paid than that—not much, but better paid than that.

So if I got back this money, I would have to pay taxes on the money. So Harvard can use all of the ten to fifteen thousand to buy health insurance, but I would only be able to use $5,000 to $7,500 of the after-tax income. So no matter how poor they are as purchasers of health insurance—and they are very poor—not because they’re stupid—they’re very smart—but because they have no idea what I want or what I would consider value for the money.

We have American employers paying for health insurance. This is unmatched in the rest of the world. The degree of financing that comes out of the corporate sector for health insurance—now, it’s not corporate money, it’s our money, but it comes out of the corporate sector—is unmatched by any other part of the world. And because we spend so much on health insurance, our employers who are globally competitive are at a huge disadvantage because they pay those costs, and the companies with whom they compete do not pay for those costs.

So, for example, General Motors, which is near bankruptcy, claims that it spends $1,600 per car on health insurance. Toyota claims it spends $100 per car on health insurance. Both of those numbers are likely apocryphal. General Motors has puffed up the numbers in a way that no economist would accept. Let’s say the right number, by including unfunded retiree health insurance—Toyota has understated the numbers by understating how much it pays for taxes for health insurance in Japan. Let’s say the right numbers are $1,300 for General Motors for health insurance versus $300 for Toyota. Can General Motors engineer $1,000 in non-healthcare costs out of its cars so it can be competitive with Toyota? I submit to you that it is impossible.

Other globally competitive firms face the same kinds of issues. Not only do they face these issues, but I’ve been on the boards of fifteen publicly traded companies—not at the same time—since many of you are academics, hardly at the same time, but I’m so old that over the course of my career I could manage it. So I do know many CEOs. I’ve never had a CEO say to me, “You know what I love about my job? I love buying health insurance.” I’ve had lots of CEOs say to me, “You know what I hate about my job? I hate buying health insurance.” But because of this tax peculiarity—they could cash us out. They could say, “Take the money and buy health insurance on your own account.” But because of this tax peculiarity, they have to buy health insurance.
I was on the board of the great company John Deere. John Deere had to build its own healthcare system in the rural parts of the United States. So here’s John Deere, this excellent company, globally competitive, ferociously competitive market, and they have to worry about delivering health care, which, as you know, is so taxing in and of its own.

There are other big problems. The 40-million-plus uninsured is, of course, a huge problem. It is a huge moral problem and may also be an economic problem. Perhaps you don’t know that over a quarter of the uninsured earn more than the median family income in the United States. In fact, people who earn over $75,000 a year are among the fastest rising number of uninsured. What is $75,000 a year? That puts you in the top 20 percent of American wage earnings. So people who are wealthy increasingly do not buy health insurance. Why is that? Well, you make $75,000. You take home $37,500 after taxes. If you live in Massachusetts, a family health insurance policy will cost you $15,000 out of your take-home pay of $37,500. Not going to do it.

So another issue, another economic issue that people don’t talk about much but to me is a major issue—the source of the wealth in this country is our incredible rate of growth of productivity. The fact that we grow so rapidly is astonishing, because we’re such a big economy that it’s like an elephant doing a backflip. So this productivity enables us to be charitable to do the things that we all wish, want to do.

So where does the productivity come from? It comes overwhelmingly from small companies. They are the major sources of new jobs in the economies. Small companies do not offer health insurance. Most of the employed uninsured work in small companies. So we have a lot of people who work in big companies who would love to work for small companies but are locked in their jobs because they fear the problems of getting insurance in the individual market. And there are millions who are underinsured. I’m going to talk about that. That’s my problem statement. So how did this happen?

Well, I think it happened because we took this money—2.2 trillion dollars—and we turned it over to insurers, the U.S. Congress, the hospitals, and we said, “Here, you take it, and you’re not going to be accountable for it.” So, for example, this morning, if you ate some Raisin Bran or a yogurt, and you looked at the side of the box, it would have a lot of information about the characteristics of that Raisin Bran or yogurt, and it would have the price pasted right on it. If you needed a mastectomy or a prostatectomy, you would know nothing about the caliber of the surgeon who is doing that procedure, nothing about the hospital in which he or she practices. You wouldn’t even know the price, even the rack rate, which is the outrageous price that’s saved only for the uninsured. Even that number is very hard to get, and that is nowhere close to the real price. When you don’t hold people accountable and you just shovel money at them, well, it’s never enough.

So what have we gotten? One thing that we have is the hospital sector has increasingly consolidated throughout the United States, become oligopolistic or monopolistic. The hospital sector is the single biggest part of the U.S. healthcare system. And in some parts of the United States 80 percent of all admissions are in one hospital system. When you don’t have competition, prices go up. And there are excellent economic studies that show that prices have risen substantially over what they would have been because of this absence of competition, and that quality of care may have diminished.

Now, there was some comment earlier about the—I think it was you, Nick—about the amount that people spend on health care. So it’s well known that as incomes go up, countries spend more on health care, because people want to. We may not like it, but they want to, and they do. Nevertheless, the U.S. spends so much more than countries of similar wealth. And McKinsey studied this issue. I don’t do any consulting—not that I’m deluged with offers, but I don’t do it. So I’m not shilling for McKinsey. But McKinsey studied this issue, and they found that our healthcare system costs half a trillion dollars more than systems in countries of equal wealth, and there are countries that are as rich—not in total but per capita—as the United States. The question is why, and the answer is lack of productivity, lack of competition, 80 percent of that caused by hospitals.

Now, I’m here in Washington, D.C., where Uncle Sam—I don’t know if you can see this—he’s got a stethoscope—has increasingly become Dr. Sam and intruded into the practice of medicine. I call it intrusion because medicine is the youngest science. You can compare the predictive power of a science like physics with a science like medicine. There is absolutely no comparison. And formulas that try to lock down cause and effect in the practice of medicine are pernicious.

And I have in my book how the Congressional insistence on high doses of EpoGen in the treatment of people with end-stage renal disease—my book focuses on a man who has end-stage renal disease. It is something like Murder on the Orient Express. All of you are too young to remember that. But that was written by the great authoress and very smart businesswoman Agatha Christie. And somebody dies on the train, the Orient Express, and the question is who killed him, and the answer
is everybody on the train killed him. Same thing with my character, who has end-stage renal disease.

So what did the Congress do to kill him? Well, one of the things they did is they have a recipe for the treatment of end-stage renal disease which is three days, three times a week, of dialysis, not much health promotion and testing, and a whole lot of Epo. And I have a Senator who is talking about the level of hematocrit that you need, and the level of hematocrit in his view that you need is the same as the level of—now, this Senator—you cannot go into the Congress and not be overwhelmed by how smart these people are. Uzbekistan, Iran—you know, it just goes on and on. Nevertheless, are they physicians? This particular Senator was a lawyer, and it turned out the Epo recommendation was quite a deadly recommendation.

Now, I teach a class at the Harvard Business School that’s called "Innovating in Health Care." I have eighty students. Twenty of them are MDs. They're not MD/MBAs. They're fully trained MDs. They're nearly as old as I am. And they've given up. They say, "I cannot practice medicine anymore. I've lost my professional autonomy, and I've lost my financial ability." Now, some people say, "Well, jeez, $120K doesn't sound bad to me." But it sounds bad to them, and they have opportunity costs that are quite real, and they're deserting the medical profession, to me a tremendous tragedy, in part brought on because of Uncle Sam becoming Dr. Sam. And the insurers are really beyond conversation.

But one problem with the insurers, with the private insurers, is the American economy is characterized by choice. We have 240 models of automobiles. We have 180,000 book titles. As an old author and teacher, I'll tell you, people buy books. They don't read books. But okay. Five hundred brands of chocolate, as if we needed them. Now, why do we have so much choice? Well, if you're a manufacturer, you're not going to offer choice unless you make money at it, and you're not going to make any money at it unless people respond to that choice.

Now, health insurance is greater than a trillion dollars. How much choice do we have in health insurance? We have one policy, which is called a PPO. Most people haven't even got a clue as to what that is. And then we have something that people call consumer-driven health care, which is an absurd title, for the second choice in what should be a market that's characterized by enormous choice. When there's no choice, there's no competition. When there's no competition, there's no productivity.

So where are we going? Well, managed care used to be a solution, and if you like, I'll tell you about why it died. But what we're looking at now—I think there is a broad consensus about the uninsured. I think except for minor parts of the right, both Republicans and Democrats agree there should be universal coverage. The question is how to do it. And there are two frameworks.

One kind of thinking is big is beautiful. Yeah, we'll have universal coverage, but that's not going to solve these costs and quality problems. The way to solve it is to consolidate the healthcare system. We have too many physicians who practice independently. We have 650,000. Seventy-five percent of them practice independently, nonsalaried. Fifty-seven hundred hospitals, a lot of independent insurance companies—the economist would say there is too much fragmentation in this market. Let's consolidate it, and big is beautiful.

An opposing point of view, totally different, is you've got this all wrong. The only way we're going to make health care better and cheaper is to bring the entrepreneurs, and let the flowers bloom, let people who have different ideas about how to deliver health care and health insurance and health information into the mix.

So what are the "big is beautiful" techniques? This is what the incoherent debate—incoherent at least to me—maybe not to you—at the Presidential and state levels is really about, these two techniques. I think the uninsured issue is a nonissue anymore, in that there is agreement that everybody should be insured. So the "big is beautiful" technique—one of them is single payer. And the theory of the case here is not only universal coverage, because universal coverage does not require a single payer, but that the government will pay, and the idea is all these insurance companies—and I certainly am no booster of them—would be eliminated, and all the money that’s wasted would be used for other purposes.

What's the problem with single payer? If you believe that the U.S. economy owes its strength to entrepreneurialism, no entrepreneur will enter a single-payer system. So, for example, Tony Blair, when he expanded the U.K. capacity to deliver health care, he sent out—the NHS sent out bids to firms in the U.S. saying, "Come to the U.K. and help us build up our capacity." I have a friend who runs an entrepreneurial specialty hospital that specializes in orthopedic surgery. This would've been
a huge contract for him, would’ve made his business. He refused to bid, and I asked him why, and he said, "It's suicidal. Tony Blair leaves office. The government changes its mind. I've invested all this capacity. I've wasted my money."

Managed competition is another "big is beautiful" technique. It is oxymoronic, at least to me. Competition is either competitive, or there is management, regulation of the sector. We have this in Massachusetts. So what do we have in Massachusetts? If you're uninsured, you can buy health insurance, but you can buy it in only one store. That store is run by the government of Massachusetts. And you could buy a number of health insurance policies, but they're all designed by the government of Massachusetts. And because—let's face it—you're not too smart, these insurance policies are very similar to each other.

So what would you expect in a system like this? The federal employees health benefit program is a very similar kind of system. One thing you would expect is that the products would all be Mercedes, because they're not designing products for the consumers' point of view, they're designing what they think you need. So if this were a car, you would have a market where every car came with a heated seat, because, after all, you need it for your little tushie. And you might say, "No, I don't need it, because it costs $2,000. I will put a little pillow with wool on it, and that'll do just fine for me." But you don't have that choice. So already in Massachusetts we've excused some of the uninsured from participation, because the plans are too expensive. And the federal employees health benefit program for the very well paid federal employees had 5 percent uninsured, likely because they cannot afford those rich plans.

Pay for performance—that sounds fabulous. You pay a good doctor more than you pay a bad doctor. Although that’s a little funny. Which is the better car? The Toyota or the Mercedes? I know what the better car is, because I own a Mercedes. Unquestionably the Toyota is the better car, and it is a much cheaper car. So the idea that high price equals high quality is not true in most of the market. But, okay, let's say that it is—do you really get paid for performance under "pay for performance," or do you get paid for conformance, for conformance with recipes that have been cooked up? Now, the danger of being paid for conformance is those recipes better be bulletproof, which is very dubious, given the youthfulness of the science of medicine.

Why don't we pay for performance? Performance in a car means miles per gallon. What happens when I hit a wall at thirty miles per hour? What is the fuel efficiency? That's what I'd like to know when I go to see a doctor or a hospital. I don't care whether they conform with somebody's ideas about how to render medical care. I really would like to know how many of their patients on a risk-adjusted basis die. What kind of morbidity do they have? What kind of clots, infections, readmissions within thirty days? Well, we don't have this data, so we can't have that.

So "let the flowers bloom" is very different. I'm going to tell you about that, and then I'll open this up. This is called—I call it consumer-driven health care. So every consumer is required to buy health insurance. If they're poor, they get enough monies so they can go and buy it themselves. They have information, which we do not have now—which doesn't exist. It's not that somebody, some secret cabal has this information. It doesn't exist. But they are empowered with information. Government helps the poor; prosecutes fraud and abuse, which it's done not very well; enables transparency; and stops being Dr. Sam, gets out of the way.

Now, what is the theory here? This is a kind of strange theory. So the theory in consumer-driven health care is consumers—if you give them—give me ten to fifteen thousand dollars. I am going to look for totally different health insurance from what I have right now. I don't want what I have. And I will likely change also the out-of-pocket healthcare services and technology. Now, what I want may not be what you want or you want or you want. We're all going to change it.

Second part—much more important—is if you put consumers—you give them the money—you all know the 80/20 rule? This is Pareto's law. Pareto's law is that 20 percent of the possible causes, cause 80 percent of what happens. For example, 80 percent of the beer in the United States is drunk by 20 percent of the beer drinkers. And as a teacher in a graduate school of business, I know them all intimately. So when businesspeople talk about low-hanging fruit, and you think, "What the heck are you talking about," they're talking about 80/20. They're going to go after the 20 percent of the market that accounts for 80 percent of what happens.

So if we want to remedy the cost and quality problems in health care, a very obvious place to start is 20/80, if it applies, and of course it applies. Twenty percent of the users account for 80 percent of the costs. They're very sick. They have a handful of diseases. They have diabetes, cancer, AIDS, heart disease, and so on. What they want is personalized medicine. They want care that's integrated around their needs. They don't have that. So if you're diabetic right now, you have to run all over
town to get your ophthalmologist, your nephrologist, your cardiologist, your podiatrist, your neurologist, your social support. But in a consumer-driven system, these units would spring up. Why would they spring up? Because that’s what people want, and they will pay for the things that they want, and also personalized technology.

Do we have the model for this? Well, sort of. Secretary Leavitt happens to be there right now. He was there yesterday. This is the country of Switzerland. Switzerland has kind of a non-wacko country, really a remarkable country, very wealthy despite the absence of any natural assets other than terrific milk that makes the milk chocolate. But the Swiss have a universal-coverage, consumer-driven system.

So here’s how it works in Switzerland. You buy your own health insurance in Switzerland. You have to buy it. These Swiss, they’re not fooling around. You lose a critical body part if you don’t buy it. It’s actually enforced through the employers. You cannot hire somebody who doesn’t have health insurance. So if you’re poor—we talked about how doctors don’t accept Medicare. The real tragedy is doctors who don’t accept Medicaid. Forty percent of physicians in some states will not take Medicaid patients, and I don’t blame them. They’re very poorly paid. So should physicians be the instruments of something that should be funded by all of us? All of us should pay for the poor and not make it a burden on physicians.

So if you’re Swiss, there is no Medicaid. There is no Medicare. There’s no government program. You go out in the private market. Poor get money transferred to them. They go out and shop like everybody else. Now, the Achilles’ heel of the individual consumer-driven market is the problem of 80/20. If I had end-stage renal disease at my age, my costs would be $65,000 a year. If Harvard gave me back 10 to 15 thousand, and I said, "Here I am," no insurer would insure me, or would not insure me for more than one year.

So how do the Swiss deal with this? Well, the private insurers have formed a cartel, and they risk-adjust each other. So, for example, if I am in Switzerland, and I live in Zurich, I would pay the insurance for a woman of my age, 35. Now, if the insurers on this end of the table over here were very devious, and they got only the healthy 35-year-old women, they would make a bundle, because they pay the average. These guys were so well intended and wonderful but hapless business people. They would lose their shirts if they enrolled all the sick 35-year-olds. So the Swiss insurance industry has formed a cartel, and they take the profits out from these guys that have been earned solely by cherry-picking the population, and they give them to these guys. So they enable an individual market where the sick can get health insurance.

And there’s terrific consumer information. Why is there terrific information? Why is there such great information on your little yogurt, on your Raisin Bran, about your cars, about Zagat’s ratings? People don’t want to be stupid. If there’s a consumer market, there’s a huge demand for information. Bloomberg—how did Bloomberg become a billionaire? Bloomberg understood—as an old accounting teacher, I’ll tell you what he understood. Most people don’t know a debit from a credit, cannot possibly interpret financial statements, and he made financial information easy for them to access. And if you use Morningstar—know what it is? Star rating for mutual funds? Terrific rating system. You can be as thick as a brick, and if you rely on Morningstar, you’ll do pretty well in your investments. So consumer markets create information.

So what are the results? The Swiss spend 40 percent less than we do. Do they spend 40 percent less by rationing care to the sick? That’s a very easy way to spend less money. You know, you can have a universal health insurance system which is great, except for the sick. Do the Swiss have that? No, they do not have that. And I compared in this boring article that I think you have—I compared Switzerland not to the U.S., because that’s a slam-dunk. Everybody’s better than the U.S. I compared Switzerland to the state in the U.S. that is most Swiss-like—very undiverse, very urbanized, highly educated, very wealthy. What is that state?

DR. MCHUGH: Massachusetts.

PROF. HERZLINGER: Massachusetts—no. Massachusetts was number 2. It’s Connecticut. I thought it would be Utah, Minnesota. Nothing like looking at data. No, it was Connecticut. So you think about a rich state, which actually Connecticut, Massachusetts, and Maryland are the three Swiss states in the United States—most Swiss-like. The Swiss have much better health care and much more in the way of resources, yet they spend 40 percent less.

So do people want choice? Netflix has 60,000 titles. You’re all too busy to watch Netflix. But, anyway, how many are rented once a day? You’ll never see me again, right? You’ve never seen me before; you’ll never see me again. So what is the answer to this? Do people like choice?
SPEAKER: To a degree, they do.

PROF. HERZLINGER: How much of a degree here?

SPEAKER: Five percent?

PROF. HERZLINGER: Five percent—that's what I thought, exactly that. That was so wrong.

Thirty-five to forty thousand titles rented every day. So people like choice. Do they want choice in health insurance? Well, the health insurance sector is lucky that the postal service exists, because the only sector in the U.S. that's more disliked than them is the postal service. So people think consumer-driven health care is high deductible. That's ridiculous. High deductible is one of many options that will emerge in a consumer-driven market.

In the Swiss market it is by far the cheapest kind of policy. Like, no kidding, if you have a deductible of $1,000 to $7,000, the policy's going to be cheaper. But only 40 percent of the Swiss sign up for it. They want to pay more to get different kinds of health insurance. And I can tell you what we know about them. We do know they reduce costs by reducing utilization of health care.

What does this do to health status? Do people reduce utilization of health care in a way that diminishes the health status? The Rand experiment, that old experiment, said no for middle class and upper class; yes for lower income people. What we do know so far, and it's very early on—we've only had these for three years—is actually people with chronic diseases who used to be in a PPO who have switched over in a high deductible take better care of themselves. This is amazing. I was astonished to see this. They actually complied more with their medications—and as you know, for chronic disease, self-care and compliance with medications is critically important.

And McKinsey again said to these people, “What happened to you? You used to be completely negligent and a slob, and suddenly you’re taking much better care of yourself with this high deductible.” Not everybody—this is average data. People said, “Well, you know, it’s my money. I have to take care of myself, because I’m spending my money.” So the psychology changed behavior. And this is just some more.

Let me tell you what I'm going to buy if you give me my ten to fifteen thousand dollars, and if you come to the Harvard Business School—anybody here? No? Right next door is a building—come visit me—that looks like a church. It's a drug factory, but it's in Cambridge, so it has to look like a church. So what does this drug factory make? Makes a personalized-medicine drug, makes a drug—the company is called Genzyme. The drug is called Cerezyme, for people who have mutated genes and get a disease called Gaucher's disease. Genzyme earns 1.2 billion dollars a year from this drug, and this isn’t Claritin or Pepcid. This is—you take the drug, you live; you don’t take the drug, you die. One-point-two billion—how many people take this drug?

DR. McHUGH: A thousand?

PROF. HERZLINGER: Three thousand. Three thousand into 1.2 billion is $400,000 per person per year. My insurance policy, and likely yours, unless you're on Medicare, tops out at a million dollars. Two and a half years on Cerezyme, you're uninsured and uninsurable. So if I bought my own health insurance since I went to MIT—and clearly the only reason you would go to MIT is—because it's not a party school—is that you love technology—I understand these things are going to cost a lot of money, and I would buy insurance for 25 or 50 million, likely taking a year cut on some other features.

How about this policy? How many of you go to the gym three times a week or more? How many of you torture yourself in what you eat or do not eat, your alcohol intake, your management of stress, your drug use? Right? Horrible life. You torture, torture every single day. What reward do you get for this? Zero reward. Now, in Switzerland you could sign up for a health insurance policy—it’s a five-year policy—that measures your health in the beginning of the five years. Now, these Swiss, they’re not nice. They’re going to measure every aspect of your health. They predict what your health will be five years from now. If you’re that healthy or healthier, you get half your money back. In Massachusetts that means for all the torture I put myself through, if I stay healthy, I will get back not a weekend at the Doubletree but $38,000—you know, serious money.

Now, you can only do this in a five-year policy. The reason is, if you're morbidly obese at the beginning of this period, it’s going to take you a long time to change your habits so that you’re healthier. It’s not going to be done one, two, or three. Why don’t we have these policies? No employer wants to sign a five-year policy. First of all, they have too much turnover in their employees. Secondly, the typical employer fires their insurance company every three to five years. If
they sign up for a five-year policy, they’re stuck with them forever.

Consumer-driven market totally—in other words, we could get health insurance policies that financially reward health promotion, that aren’t hoarded—don’t say do this, do that, do that—but instead they hand out a carrot—and what a carrot—a 38-thousand-dollar carrot. So we had this before. What’s going to happen in supply is radical restructuring of the healthcare system to personalized health services, personalized diagnosis, personalized therapy that deals with the fragmentation of the present system. We’ve seen this in breast cancer, and in part as a result of this we’ve had lower deaths and lower costs.

Why don’t we have personalized health care now? Why don’t we have organized teams for diabetics, for people who have AIDS, for people who have congestive heart failure? So Duke University understood 80/20 very well, and they started an integrated program for people who have congestive heart failure. As opposed to top-down technocratic dictates about how to manage care, they came up themselves organically with a new idea. They increased the visits to cardiologists sixfold. They improved health status so much that they reduced the number of hospitalizations and lengths of stay in one year—one year.

I’ll tell you this as an economist. This is an astonishing entrepreneurial innovation. In one year they reduced total costs by 40 percent by making people healthier. Not by saying no, just by making people healthier. What reward did Duke University get for this innovation? Henry Ford—he became wealthy. Bill Gates, wealthiest man in the world. What about this? Have you ever heard of this? No. The reason is they lost every penny they saved, and they reason they lost every penny they saved is in today’s system providers don’t get paid for making people healthy. They get paid for treating the sick. So the healthier they made people, the more money they lost. Can you imagine how pernicious this payment system is? And it all comes out of CMS and the insurers, that not only dictate price but dictate the bundles in which you render care. So entrepreneurial—you know what they say—no good deed goes unpunished. Right now that’s what happens in healthcare services.

So who’s going to change all this? Who started Microsoft? Bill Gates. Who started General Electric? Thomas Edison. I knew you guys were smart. Who started Ford? Well, that’s a gift. Who started Genentech? Genentech used to be called Herbob, as if it were an automobile dealership. Herb was the Nobel-worthy scientist; Bob was a businessman, Bob Swanson. So Duke University started an integrated program for people who have congestive heart failure. As opposed to top-down technocratic dictates about how to manage care, they came up themselves organically with a new idea. They increased the visits to cardiologists sixfold. They improved health status so much that they reduced the number of hospitalizations and lengths of stay in one year—one year.

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What did these people share other than they’re all white men? Please help me. This is ridiculous here. What else did these people share? They’re rich. Actually, John Bogle is not that rich. John Bogle could have well, you don’t want to hear about that. But he’s rich. He’s not crying poverty, but he’s nowhere near as rich as his counterpart, the head of Fidelity, because Vanguard is owned by its employees. He’s quite a charitable man. I wish he would win the Nobel in economics before he gets too old.

So clearly these are all path-breaking businesses. These aren’t minor innovations. And all these people are not only very good business people, but they really know what they’re doing. So Bill Gates is a software writer, is extraordinary software writer. John Bogle could manage money like nobody’s business.

So if you’re that kind of person in healthcare right now, you’re completely shackled. The payment system shackles innovations in services. Insurance regulation shackles innovations in insurance. And if you’re a technology entrepreneur, come take my course, where I spend a lobotomizing two weeks on how to navigate the shoals of coverage, coding, and pricing, so that you can actually get paid for your entrepreneurship.

So there are a lot of scare stories, but I’m going to tell you just deal with a couple of them. One of them is there is no information. And there is no information. So how can you have a consumer-driven market when there is no information?

We had this situation. In 1934 we had a great depression. Accounting in the middle of the fifteen th century. We talk about globalization as if it’s brand new. Of course, that’s ridiculous. So the Italians discovered accounting because they were trading all over the world, and they needed some way to keep track of what they were trading.

We did not have financial statements for corporations until 1934. When you bought a stock before 1934, that was like going to a hospital or a doctor right now. You had zero information. So what happened? What changed things in 1934? Franklin Delano Roosevelt gets elected. He is urged—same debate: big is beautiful versus let the flowers bloom. He is urged to take over the U. S.
Franklin Delano Roosevelt is an aristocrat, a very wealthy man, whose money came totally from his mother, Sarah, who lived with him and Eleanor. So you wonder why this wasn’t a happy marriage. So he is, of course, an incredible genius, a genius in so many ways, and he invented transparency—what now trips off our tongue: transparency; there was no transparency—with the SEC, which said, “You’d better measure. You’d better make it public. You’d better get it audited, or you won’t have access to any money.”

So we need an SEC in healthcare, and we need it because of information like this. This came from Engenics, which is a subdivision of United Health Care, a small subdivision, a mere billion dollars. So this is a cost-quality relationship for physicians. It’s like the Toyota relationship. The highest price is not necessarily the highest quality, but in the absence of disclosure who the hell knows this?

Here is what I do know. This is information I got off the website in Massachusetts on the hospital 30-day, risk-adjusted mortality from heart attack compared to U.S. national rate. Of all the great hospitals in Boston, and they’re either average, better than average, or worse than average. Gee, funny thing. They’re all average.

What is the probability of all of those hospitals being average? What kind of distribution and standard deviation do you have to get so that they are all average? These are political data rather than informative kind of data. They’re the kinds of information we now get.

Class warfare: the sick are going to get better healthcare than the poor. Do the sick get better healthcare than the poor once they get care? Poor have clearly much worse access. Yes or no? The rich get better healthcare than the poor. That’s the class warfare. That’s what they say about consumer-driven healthcare. The answer is no, in the lobotomizing prose of The New England Journal of Medicine. So what you see at the bottom here is—this is the Rand team, this wonderful team at Rand that studies these questions.

The reason you needed an army to answer this question is we have no measures of quality. So, you know, it is a very difficult question to answer. Of course, the rich think they get better healthcare because they are rich and connected and powerful, but in the absence of data about quality of care, in their opinion, no, it’s not true. Whereas I can get terrific data about as trivial a purchase as a car or a donut or a yogurt, no information—we won’t get it until we get the SEC.

So here is where I think we’re going. We’re going to have—whether Hillary or whoever on the Democratic side or whatever Republican. We’re going to get tax relief so that consumers can buy on the individual market. Poor people will be subsidized. I have pitched this healthcare SEC to every politician I know. None of them have bitten. They’re terrified of the backlash from providers of measuring performance. No provider—nobody wants to have their performance measured, including professors. You know, we want other people’s performance to be measured but not our own. But it will come. We cannot have a consumer-driven market without it. And on the supply side, we need to get rid of these restrictions that inhibit fabulous entrepreneurial activities like the Duke innovation or the insurance innovation.

So that’s it. I’d be glad to—is this the format? I’ll just sit down.

CHAIRMAN PELLEGRINO: We’ve asked our council member Nick Eberstadt to open the discussion.

DR. EBERSTADT: Well, Professor Herzlinger, first of all thank you for a wonderful presentation, which was both informative and enjoyable.

DR. HERZLINGER: Thank you.

DR. EBERSTADT: Very nice to see those two qualities together in one neat package.

DR. HERZLINGER: Well, you know, if you teach accounting you better be funny.

DR. EBERSTADT: And thank you also for two submissions to our folders, the JAMA article and the chapter from your book. Having been trained a little bit in economics, I have to say that I’m in violent agreement with you about the benefits of competition and certainly the propitiary effects of more market-oriented approaches. And naturally when one thinks about healthcare, the logical agents or units here are what we call the healthcare consumer, so that consumer-driven healthcare seems to me to have an awful lot of potential benefits, certainly on the margin and maybe even further than that, the sorts of basic things that we expect in sort of an economic system from more
competition of this sort, more efficiency, more consumer welfare, and even some measure of improved equity.

I think that you've made very persuasive cases for all of these. If I have to quibble—and I think that my assigned task here is to quibble a little bit—how would I go about it? In the Swiss example, certainly the results that one sees in Switzerland in terms of public health are really impressive. To some degree I think that one has to bear in mind that public habits are also somewhat different in Switzerland, even from Massachusetts and New England. One looks at things like body mass index and things like that. People who are going up and down the mountains all the time just have a lot lower incidence of obesity and other things which may predispose them towards better health results to begin with.

I think we also want to bear in mind that, big as that difference is, Switzerland, I believe, has the second highest ratio of health expenditures to GDP of any country.

DR. HERZLINGER: It's next to us.

DR. EBERSTADT: They're the silver medalists, right, on this one?

DR. HERZLINGER: Right. In a contest nobody wants to be the gold medalist in.

DR. EBERSTADT: Am I correct in remembering that there are quite a few criticisms within Switzerland of the existing model, especially the cantonal basis of health insurance? I mean that probably is irrelevant to this particular discussion.

DR. HERZLINGER: Yes.

DR. EBERSTADT: But one thing which I'll mention, which I just came across after I read your materials, OECD keeps a great big health database, and one of the things that they ask is they ask the public—or they compile answers from the public from people age 15 on, do you consider your health to be poor, good, excellent and the like. And if one takes a look at these data, it's a very curious result, and I'm not quite sure how to explain it. I'd say it's somewhat paradoxical.

The country that always comes in as number one or number two is the United States. Somewhere between 88 and 92 percent of the U.S. public surveyed always says their health is good or better, and this is a few points higher than Switzerland consistently, and it's about 50 points higher than Japan, which actually has the longest life expectancy of any country in the world.

Now, whether this tell us anything about our satisfaction with our crazy quilt medical system or is just public misinformation, it's a curious result, and it's even more curious because it's so stable over time. It's been stable this way for about 25 years.

DR. HERZLINGER: Yeah, it's interesting.

DR. EBERSTADT: Since we are a bioethics council, I suppose I have to try to speak to some of the ethical questions which come from consumer-driven health, which, as I say, I'm very sympathetic towards.

The question I suppose that some of our other council members may wish to entertain is whether there are ethical questions which arise from this idea of consumer self-remedy in the health and medical field. Most economic markets are supposed to work best when the agents are fully informed, when there aren't asymmetries of information, when technology is relatively fixed, and when the rules of the game—the ethical precepts—are, you know, firmly accepted. None of these things apply fully in our examination of healthcare at the moment.

If we looked at universities and we asked whether we would want to have consumer-driven education, which to some degree we do, we can see where a fully consumer-driven thing might take us with respect to healthcare.

There's also the question of who are the consumers? Do children get to serve as their own agents as consumers? Are there other people who wouldn't have full voice as consumers? This takes us beyond the margin, of course. This takes us into big changes in any sort of system. And then finally there's the question of a healthcare system oriented toward consumers. The economist in me likes this a whole lot, but I also realize that there are other arguments that could be brought to bear, and I think that some of the MDs on our panel might have things to say about the transmutation of individuals from patients to clients to consumers. That's not a totally, perhaps, costless transition for us.
Thank you very much. I really enjoyed your stuff.

DR. HERZLINGER: Thank you so much.

CHAIRMAN PELLEGRINO: Thank you very much, Nick.

DR. HERZLINGER: May I respond to one of the—

CHAIRMAN PELLEGRINO: Yes, please.

DR. HERZLINGER: People think of the Swiss as being very healthy, and I think 34 percent of them are obese, as opposed to 50 or 60 percent in the U.S., but Switzerland is where Needle Park exists, and they have, as far as overuse of illicit drugs, alcohol, and smoking, which may have something to do with the obesities in ways, perhaps, we don’t want to explore. But they smoke much more, drink much more, and use illicit drugs much more than Americans.

I’ll never be able to answer, nor would anybody else—it’s a fair point. But the Swiss are not exactly the idyllic, slim Swiss yodeling on top of the Alps that you might picture there.

CHAIRMAN PELLEGRINO: Thank you very much. Comments? Dan?

DR. FOSTER: If one gives every person, particularly let’s say the poor, the means to buy in a competitive fashion, is there any evidence about how the poor might use the money to buy a car or education instead of health insurance?

DR. HERZLINGER: Yes. In my view, health insurance purchase must be mandatory. You have to buy it, to obviate that kind of question. Will the poor be intelligent consumers? Of course, the poor are as intelligent as anybody else, in my view, but there are some data about this in a program called—what happens when you cash out the poor? In a program called Cash and Counseling, which took people who were disabled, on Medicaid, who were poor plus disabled, some of whom had emotional disabilities and intellectual disabilities as well as physical disabilities, and cashed them out, said, “Here is the money that we spend on your behalf”—and it’s a huge amount of money—the cash out came with a counselor. The Swiss actually have it that one of the benefits that you are required to buy in Switzerland is a counselor who will work with you on evaluating different things.

You could use him or her or not use him, but it is a required benefit. The Cash and Counseling Program wound up with much greater satisfaction. Some of the disabled, for example, had been abused by the aides that they’d hired, and they hired them because that was the benefit. When they could use their money in ways that they controlled, they had much higher satisfaction, and the rate of growth of costs was the same. So I take that as very heartening evidence.

The other thing that gives me heart is that in most markets the duct is very good even if the consumer is an idiot. For example, my Treo, which cost $200. When I graduated from MIT I had to program a PDP 11. I had to program it in machine language. It solved a trivial problem. It cost $150,000 and had far less computing capacity than this Treo. So that was 40 years ago.

Who made this Treo so good? Not me. Maybe you did. I have no idea how this thing works. I haven’t got a clue. I think most of the people who buy this don’t have a clue how it works, but it got better and cheaper. And the answer is that in most markets, if 20 percent of the market is very aggressive and can buy the product and has good information, they make it better and cheaper.

So in the computer market—I have a friend who has Computer Engineering News as light reading in his bathroom. He clearly made this product better and cheaper. It wasn’t me. This 20 percent, so that all of us would have access to better healthcare even if we were idiots—as long as there is this assertive marginal group in the market that makes it better and cheaper.

Does it exist in healthcare? I just looked at who is looking on the Internet at healthcare information. It’s all kinds of people, but it’s predominately well-educated, professional people. These are the kinds of people who made this Treo better, and healthcare just crossed pornography as the number one viewed site on the Internet. I think it’s 40 percent of Americans look at this.

So I think it’s a very important point, but I take—if we have the information. If we don’t have the information, forget about it. If we do have the information, this marginal group will use that information to reward the good and punish the bad.

CHAIRMAN PELLEGRINO: Dr. Carson?

DR. CARSON: Thank you for that. I must say I resonated very strongly with just about everything
youth said. A couple of questions. Do politicians not know about these things that you’re talking about, or are they just afraid to join the battle against the special interest groups in order to make the changes that would be necessary? That’s question number one. And number two, what do you think about the concept of removing from the list of responsibilities of insurance companies catastrophic healthcare, making them only responsible for routine healthcare, which could then be monitored, predicted, and controlled, and making the government responsible for catastrophic healthcare?

DR. HERZLINGER: Political? I don’t know. You’ve listened to me. I’m apolitical to a fault. I’ve talked with, I think, all the major candidates or their domestic policy advisors other than Barack Obama and Dennis Kucinich and Edwards. So I’ve talked with Hillary and I’ve talked with the major Republican candidates, and I think they are all on this. You know, Senator Clinton’s plan, for example, for the uninsured is a consumer-driven plan. You cash out the uninsured, either give them tax protection and/or give them enough money so they can go and buy and let them buy in the market.

She would create a Medicare-like choice in the federal employee health benefit program in addition to private insurance, but to me that’s clearly consumer-driven. What I think—and this may be pure hubris on my part—is healthcare is incredibly complicated, and the one politician who understands it in the present race is Senator Clinton. The other ones are dying to avoid the topic, just “Stop it. I don’t want to talk about it” because they know that even the Clintons, who are so politically adept, got killed two times.

I don’t know if you remember this, but Clinton proposed expanding catastrophic coverage for Medicare. You would think people would be out in the streets cheering. He got killed on this. So they know it’s the third rail, and they want to avoid it.

I think we’re going to have very good debate on healthcare. Right now the Republicans are punting, and they’re saying, “Leave it to the states,” which means, ”Don’t ask me any questions because I’m afraid it will go too much.” The other one who knows quite a bit about it is Romney but nowhere near as much, in my view as an old teacher, as Senator Clinton. But she’s going to force it. It’s a woman’s issue. She knows the issue. People are very concerned about this. This consensus that we must have universal coverage has come about because the American people have said we want this, you know. We want this to happen.

Now, what about catastrophic coverage by the government and standard coverage by private insurance firms? You are a very great physician, and you’ve done the most courageous things. I personally worry about the politicization of medical care and the fact that peer review can sometimes be used as a wedge to suppress innovation, to suppress out-of-the-box thinkers. I saw it in Boston with Judah Folkman, whose incredible about angiogenesis didn’t receive NIH funding for ten years.

My daughter is a physician, my husband is a scientist. I have the greatest admiration. But medicine is very political, and I worry if the power were all in the hands of one agent, not necessarily because it’s the government, that important innovations would be suppressed. I particularly worry about it now because we’re in the—medicine is about to become a real science.

So I am not wild about this. We can have reinsurance of catastrophic care through the normal private sector reinsurance markets. It’s a seven- to nine-billion-dollar industry in the U.S. There are great big companies. You know, I like a lot of eggs in that basket so that no great scientist is suppressed because he or she is politically incorrect.

CHAIRMAN PELLEGRINO: Paul?

DR. McHUGH: Professor Herzlinger, I loved that presentation.

DR. McHUGH: —because of a number of reasons, but one of them I discussed with our friend here. A senior moment.

DR. HERZLINGER: I have that. You know, when I meet my students, my children used to say to me, ”Who is that?” And I would say, ”Don’t ask me.”

DR. McHUGH: That’s the problem. Nick and I were sitting, talking between sessions, and part of the conversation we’ve been having here is between the doctors and other people. You might have been listening to it. And one of the real things that turns up, of course, in the present healthcare system is that we doctors are living under a different culture than the healthcare system is.
I live my life in relationship to my patients' benefits and very much the attitudes and assumptions and rewards and punishments I get from doctors I admire. If Dan Foster doesn't like what I am doing even for an individual patient, I am crushed, and I change. Okay?

DR. HERZLINGER: Right.

DR. McHUGH: But whether my health manager thinks I should use this routine or that routine, I try my best to get around him because I'm on the patient's side, okay?

DR. HERZLINGER: Of course.

DR. McHUGH: So we need something that restores the sense that we're all on the same page.

DR. HERZLINGER: Absolutely.

DR. McHUGH: And what you're proposing here would put us at least, it seems to me, on the same page. Nick asked the question would we worry about them being consumers. I think you can be a consumer and a patient as well. Those two things are not incompatible. It might be that being a client and a patient might be two different things, but we can talk about that with the lawyers. But a consumer and a patient might well be things you could do together.

So I like that very much, but you also have to remember that I'm a psychiatrist.

DR. HERZLINGER: I liked you up until now.

DR. McHUGH: Up until now you liked me. But that might be because of your Massachusetts experience with psychiatrists, and that's why I left Massachusetts. But that's another story. That has to be done in the Swiss way.

The things that concern us as psychiatrists are two things. The first thing and obviously the most important thing is I'm looking for equity for my patients, my mentally ill patients. I believe that they have illnesses of the same kind as they have if they have epilepsy and things of that sort. And would this consumer-driven thing be sure to provide that kind of equity and that my patients would get it?

But the second thing is, in relationship to psychiatry, which is very ideologically driven in many places—it's school driven often rather than science driven. Would the data that you want to acquire be the kinds of data that would alter practice, would lead to the improvement of things, or would it continue to support, because X and Y thinks this is the way to do, still speak about ids, egos, and superegos and all of that kind of stuff and keep that going that way or would it change? Because it needs to change.

And, by the way, I don't think that most of us doctors, at least at this table, would be at all concerned about being graded regularly. I think, you know, when I was graded I improved my performance. I think maybe I'd do better. I'm not worried about that. But I am worried if the grading system is corrupt, and so those are my questions.

DR. HERZLINGER: I think the way the insurance should be written is that everything that is viewed as medically necessary is covered but that the coverage is catastrophic, meaning if you earn $30,000 you would have to buy a very full insurance policy. If you're Bill Gates you would probably not have to buy anything at all. You could self-insure. And that mental health is widely accepted as being part of medical care.

The way the measurement process works in accounting, in economic disclosure of the performance of firms, I like the model a lot. The process is that all the people involved decide what should be measured and how it should be measured, so it not in the hands of any—for example, there is an organization called the Financial Accounting Standards Board. It's comprised of business people, of academics like me. I was on one of these fascinating standards, which I really deserve a vote of thanks for that. It's an excruciating process.

There are relevant business groups, there are consumers—anybody who is part of the process is involved. Who is not involved is any form of government. It's a totally private sector process. It would be trickier in medicine, no question, because of the political ideas about different practices of medicine. But one thing about the FASB is it's very transparent. You may not have heard of it, but if you're in the field, if you are a financial analyst or whatever. If you're interested in this, a financial economist, you follow those hearings religiously and you write about the hearings and, you know, there's a lot of transparency. It's not buried in the bowels of CMS out in Baltimore to see the light of day very obscurely.
CHAIRMAN PELLEGRINO: Dr. Hurlbut?

DR. HURLBUT: I want to ask you a broad question, but first I want to ask for something I've never been able to figure out. When they talk about the number of people who are uninsured, and you pointed out that 25 percent of them actually make above median income, what percentage are we talking about of the kind of patients that I saw in the county hospital in my training who probably couldn't even handle dealing with getting their own insurance at all. I mean indigent people, people who are mentally ill, and so forth. There are a number of those people around. What is going on with those?

DR. HERZLINGER: A number of them are insured also.

DR. HURLBUT: Yes. But what I'd like to get a sense of is who those uninsured people are. I mean, a lot of them must be young college-age students and stuff.

DR. HERZLINGER: The majority are young. The majority are employed. So to the extent that employment obviates people who are nonfunctional, which may or may not be true, but to the extent that it obviates that, most of them are functioning human beings. Six percent of them judge themselves to be very sick, only six percent. Probably it's 20 percent, you know. It's the same 20/80 out of this large population.

As to how many cannot function? I don't know. Probably a greater number than those in the insured population. That's why I found this Cash and Counseling Program such an interesting program. The disabled on Medicaid include people with Tourette's, people with emotional illnesses, people with not only physical disabilities, people with intellectual limitations. And yet with the counselor, the program worked better than the alternative.

DR. HURLBUT: Then the broader question I wanted to ask you—this is a little bit like Paul's question. You started out and you showed us this figure of $300,000, the iatrogenic deaths. I never did quite figure out, first of all, why you showed us that, what it means in relationship to your program, and the broader question is this. I assume you showed it to us because there is not competition for not killing or something like that. Is that what you're implying?

DR. HERZLINGER: There is no data that would enable consumers to make judgments about where they might get care where they have a lower probability of having some untoward event.

DR. HURLBUT: You think that that 300,000 deaths is remediable if only somebody were paying attention?

DR. HERZLINGER: If there were more transparency, unquestionably. When New York state published data about CABGs and risk-adjusted mortality and morbidity and clots and reinfection rates and blah blah blah, the results improved substantially. Those data were published. They were published not because Mark Chiasson, who was then the Commissioner of Public Health in New York, wanted them published. He wanted them kept private, but a newspaper sued under the Freedom of Information Act and made those data published.

So what happened? The caliber of care went way up. Some people said, "Well, the docs now wouldn't do very risky cases because the data were published." There's been a lot of analysis of that issue. Did physicians avoid risky cases? The average age of the people who were operated on for a CABG went up during this period and there were some other data. I don't think that's what happened. I've read a lot of testimony from physicians who were on the bottom of that list, and the physicians said, "I didn't realize how bad I was." And they either changed the way they practiced—and they changed things like how you admit somebody who has a CABG, not necessarily the surgery itself but the entire process—or they went out business.

So I have no doubt that transparency changes behavior, not only consumer behavior but provider behavior. You know, when I get poor student ratings, which I've had more than I wanted, there's a very clear message in here. You're not being relevant; you're not satisfying what the students want. And I'm not compromising the content of what I teach, but it's a real wake-up call to change the way I do it.

DR. HURLBUT: Just as a little follow-up on this. I mean, I feel the weight of what you're saying. We did a study in this council on in vitro fertilization or assisted reproductive technologies. We ran across some things that we weren't—I think we weren't very harsh on this almost industry, if you will, in medicine. But there were some things we ran into that were very, very—

DR. HERZLINGER: Troubling?
DR. HURLBUT: Troubling. And that should—since that's not funded by federal funds, at least, it should be very much like a consumer-driven dimension of medicine already. Now, maybe that's just not the structure you have in mind for it. Maybe there are no kind of IVFs counseling organizations to send you. But, for example, there's a procedure called ICSI, intracytoplasmic sperm injection, where in cases of male infertility primarily they will inject the sperm directly into the egg.

Well, it turns out you can have a much higher rate of pregnancy from this. It's a little more expensive because it involves another procedure, but it's also medically uncertain. In other words, it's probably adding an element of additional medical risk to the outcome for not just the parents who want a child but for the child him or herself.

So that's a weird situation, isn't it? There might be a whole different set of values that would have to be looked at by—now, maybe a private counseling system could do this and would do it honorably. On the other hand—you see where my question is, right?

DR. HERZLINGER: I do. It's actually very interesting to me. I was just talking with a former student of mine who is a pediatric cardiac anesthesiologist and MBA. He and his wife had sought in vitro fertilization. He is extremely knowledgeable, and it's clearly a terrible market in many ways, just a horrible market. I don't know why that is. I don't know enough about the market, but in the medical ways you've mentioned, the lack of transparency, the requirement to do tests. I can't answer your question. I haven't looked at the industry enough.

In other consumer purchases, like LASIK surgery or eyeglasses, which are consumer-driven markets, the products have steadily improved and the price has gone way down. So it may be that in vitro fertilization is so expensive and there is not real competition, that there's limited factors. As it exists right now, it clearly needs regulation. It's terrible.

But I really—I wish I could answer your question. I cannot. But I wouldn't say that that's generally true of consumer-driven healthcare. The examples we do have—most pervasive is the eyewear industry—is of steady technological innovation, improvements in products, lowering in costs, standardization, and quality.

DR. HURLBUT: One final question here. What do you see as the role of what’s been called medical tourism and travel abroad in this competitive—

DR. HERZLINGER: Yeah, I knew you were going there. Right. So I don't like the phrase “medical tourism” because it trivializes what is a very important issue, which is if you're uninsured and you need a medical procedure, a very good option is to go abroad.

I have a series of case studies which I've done that I would be happy to share with you on four Indian companies that have started hospitals in India. They are first aiming at the Indian market. The Indians spend $42 per person on healthcare, so clearly there is a lot of unbuilt capacity in India, but they are also aiming at the American market, ultimately aiming at the uninsured market.

Some countries really have tremendous specialties. You know, Thailand in gender changing—I don’t know what the term is for it, but that's clearly—what is it? Gender reassignment. That's it. It’s fabulous in gender reassignment. Costa Rica is fantastic in dentistry. Hungary is a real center of excellence in dentistry. I think this is going to be a very viable market.

JCAHO has moved to accrediting, for whatever that is worth. That also process accreditation. But the Indian hospitals, Bumrungrad—this huge hospital in Thailand—they’re all accredited. There are political problems now with having people go abroad, but if we stay the way we are, which I don’t think we are. But if they stay the way they are, I think it is imperative that we solve these political problems because you can go to a brand new, first-rate hospital in India and have surgery for a tenth or a quarter of the cost in the United States with appropriate aftercare. To bar people from doing that seems to me really unfair.

Chairman Pellegrino: Thank you very much. We have reached the end our meeting. We thank you very much again for your presentation to the Council, and we will gather tomorrow morning at nine o’clock.
EDMUND D. PELLEGRINO, M.D.

COUNCIL CHAIRMAN

Dr. Pellegrino is Professor Emeritus of Medicine and Medical Ethics and Adjunct Professor of Philosophy at Georgetown University.

He has served as Director of the Center for Clinical Bioethics at Georgetown University; head of the Kennedy Institute of Ethics and director of the Center for the Advanced Study of Ethics at Georgetown; President of Catholic University; President and Chairman of the Yale-New Haven Medical Center; Chancellor and Vice President of Health Affairs at the University of Tennessee; founding Chairman of the Department of Medicine at the University of Kentucky; and Founding Director and Vice President of the Health Sciences Center, State University of New York, Stony Brook, where he oversaw six schools of health sciences and the hospital, and served as Health Affairs Dean of the School of Medicine.

He has authored or co-authored 24 books and more than 550 published articles; is founding editor of the *Journal of Medicine and Philosophy*; a Master of the American College of Physicians; Fellow of the American Association for the Advancement of Science; member of the Institute of Medicine of the National Academy of Sciences; recipient of a number of honorary doctorates; and a recipient of the Benjamin Rush Award from the American Medical Association, and the Abraham Flexner Award of the Association of American Medical Colleges.

In 2004, Pellegrino was named to the International Bioethics Committee of the United Nations Education, Scientific and Cultural Organization (UNESCO), which is the only advisory body within the United Nations system to engage in reflection on the ethical implications of advances in life sciences.

Throughout his career, Dr. Pellegrino has continued seeing patients in clinical consults, teaching medical students, interns and residents, and doing research. Since his retirement in 2000, Dr. Pellegrino has remained at Georgetown, continuing to write, teach medicine and bioethics, and participate in regular clinical attending services.
FLOYD E. BLOOM, M.D.

COUNCIL MEMBER

Floyd E. Bloom was until March 2005, Chairman of the Department of Neuropharmacology at the Scripps Research Institute. He is currently professor emeritus in the Molecular and Integrative Neuroscience Department at TSRI, and the founding CEO and board chairman of Neurome, Inc. He previously was Director of Behavioral Neurobiology at the Salk Institute and Chief of the Laboratory of Neuropharmacology of NIMH.

He has received numerous awards, including the Pasarow Award in Neuropsychiatry and the Hermann van Helmholtz Award, the Sarnat Award for Mental Health Research, as well as a number of honorary degrees from major universities. He was the editor-in-chief of Science magazine from 1995 to 2000.

Dr. Bloom was born in Minneapolis, Minn., in 1936. He attended Southern Methodist University in Dallas, Texas, where he received an AB degree cum laude and then an MD degree, cum laude from Washington University in St. Louis, Mo.

He is a member of the National Academy of Science (1977), The Institute of Medicine (1982), The American Philosophical Society (1989) and the Royal Swedish Academy of Science (1989).

Dr. Bloom has authored or co-authored a total of 32 books and monographs, 415 original research articles, 256 solicited articles and reviews, 59 editorials, and more than 300 abstracts.
BENJAMIN S. CARSON SR., M.D.

COUNCIL MEMBER

Benjamin Solomon Carson Sr. is the Director of Pediatric Neurosurgery at the Johns Hopkins Medical Institutions, a position he has held since 1984. He is a professor of neurosurgery, oncology, plastic surgery, and pediatrics.

In 1987, he gained world-wide recognition as the principal surgeon in the 22-hour separation of the Binder Siamese twins from Germany. This was the first time occipital craniopagus twins had been separated with both surviving. In 1997, Dr. Carson was the primary surgeon in the team of South African and Zambian surgeons who separated type-2 vertical craniopagus twins (joined at the top of the head) in a 28-hour operation. It represents the first time such complexly joined Siamese twins have been separated with both remaining neurologically normal.

He is noted for his use of cerebral hemispherectomy to control intractable seizures as well as for his work in craniofacial reconstructive surgery, achondroplasia (human dwarfism), and pediatric neuro-oncology (brain tumors).

Dr. Carson is a recipient of numerous honors and awards including more than 20 honorary doctorate degrees. He is a member of the American Academy of Achievement, the Horatio Alger Society of Distinguished Americans, the Alpha Omega Alpha Honor Medical Society, and many other prestigious organizations. He sits on many boards including the Board of Directors of Kellogg Company, Costco Wholesale Corporation, Yale Corporation (the governing body of Yale University), and America's Promise.

He is the president and co-founder of the Carson Scholars Fund which recognizes young people of all backgrounds for exceptional academic and humanitarian accomplishments.

He is the author of Gifted Hands, THINK BIG, and The Big Picture.

Dr. Carson has been married to Candy Carson for twenty-five years and has three sons.

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REBECCA DRESSER, J.D., M.S.

COUNCIL MEMBER


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Nicholas N. Eberstadt, Ph.D.

Council Member

Nicholas Eberstadt is the Henry Wendt Chair in Political Economy and Government at the American Enterprise Institute in Washington DC. He is also Senior Adviser to the National Bureau of Asian Research, and for many years was a member of the Harvard University Center for Population and Development Studies.

His areas of inquiry include demography, economic development and international security. He has served, inter alia, on the Board of Scientific Counselors for the US National Center for Health Statistics, the Visiting Committee for the Harvard School of Public Health, and the Global Leadership Council of the World Economic Forum.

His many books include *Poverty In China*, *Fertility Decline in the Less Developed Countries*, *The Tyranny of Numbers*, *Prosperous Paupers* and Other Population Problems and *The Poverty of "The Poverty Rate": Measure and Mismeasure of Want in Modern America*. 

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Daniel Foster, M.D. John Denis McGarry, Ph.D. Distinguished Chair in Diabetes and Metabolic Research, University of Texas Southwestern Medical School. Dr. Foster, whose research is in intermediary metabolism, has received the Banting Medal, the Joslin Medal, the Tinsley R. Harrison Medal and the Robert H. Williams Distinguished Chair of Medicine Award for his work. He is a member of the Institute of Medicine of the National Academy of Sciences and is a Fellow of the American Academy of Arts and Sciences. He was chairman of the Department of Internal Medicine at UT Southwestern for 16 years.
MICHAEL S. GAZZANIGA, PH.D.

COUNCIL MEMBER

Michael Gazzaniga, Ph.D., is the outgoing David T. McLaughlin Distinguished University Professor in Cognitive Neuroscience and Director of the Center for Cognitive Neuroscience at Dartmouth College and the incoming Director of Sage Center for the Study of Mind at the University of California, Santa Barbara. Dr. Gazzaniga conducts research on how the brain enables the mind. He is a fellow of the American Neurological Association, as well as the president of the American Psychological Society and a member of the American Academy of Arts and Sciences and the Institute of Medicine. His publications include *Cognitive Neurosciences III* (2004), *The New Cognitive Neurosciences* (2000) and *The Mind’s Past* (1998). His new book, *The Ethical Brain*, was published in 2005.
Robert P. George, J.D, D.Phil.

Council Member

Robert P. George is McCormick Professor of Jurisprudence and Director of the James Madison Program in American Ideals and Institutions at Princeton University.


In 2008, Professor George received the Presidential Citizens Medal at a ceremony in the Oval Office of the White House. He is a winner the Bradley Prize for Intellectual and Civic Achievement; the Sidney Hook Memorial Award of the National Association of Scholars; and the Philip Merrill Award for Outstanding Contributions to the Liberal Arts of the American Council of Trustees and Alumni.

A graduate of Swarthmore College and Harvard Law School, Professor George earned a doctorate in philosophy of law from Oxford University. He was elected to Phi Beta Kappa at Swarthmore, and received a Knox Fellowship from Harvard for graduate study in law and philosophy at Oxford. He holds honorary doctorates of law, letters, science, ethics, civil law, humane letters, and juridical science.

Professor George is a member of UNESCO’s World Commission on the Ethics of Scientific Knowledge and Technology. From 1993-98, he served as a presidential appointee to the United States Commission on Civil Rights. He is also a former Judicial Fellow at the Supreme Court of the United States, where he received the 1990 Justice Tom C. Clark Award. He is the recipient of a Silver Gavel Award of the American Bar Association, the Paul Bator Award of the Federalist Society for Law and Public Policy. In 2007 he gave the John Dewey Lecture in Philosophy of Law at Harvard. In 2008 he gave the Judge Guido Calabresi Lecture at Yale and the Sir Malcolm Knox Lecture at the University of St. Andrews in Scotland.

Professor George is a member of the Council on Foreign Relations, and serves as Of Counsel to the law firm of Robinson & McElwee.
Alfonso Gómez-Lobo, Dr. phil.

Council Member

Alfonso Gómez-Lobo, Dr. phil. Ryan Family Professor of Metaphysics and Moral Philosophy, Georgetown University. Professor Gómez-Lobo specializes in Greek philosophy, Greek historiography, the history of ethics, and contemporary natural law theory. He is the recipient of several awards, including a research fellowship from the Guggenheim Foundation. His latest book, *Morality and the Human Goods*, was published by Georgetown University Press in 2002.
WILLIAM B. HURLBUT, M.D.

COUNCIL MEMBER

William B. Hurlbut, M.D. Consulting Professor, Department of Neurology and Neurological Sciences, Stanford Medical Center, Stanford University. Dr. Hurlbut’s main areas of interest involve the ethical issues associated with advancing biotechnology and neuroscience, the evolutionary origins of spiritual and moral awareness, and the integration of philosophy of biology with theology. He has worked with the Center for International Security and Cooperation on a project formulating policy on Chemical and Biological Warfare and with NASA on projects in astrobiology. He is the author of "Altered Nuclear Transfer," a technological proposal to our nation's impasse over stem cell research.

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PETER A. LAWLER, PH.D.

COUNCIL MEMBER

Peter Augustine Lawler is Dana Professor and Chair of the Department of Government and International Studies at Berry College. He teaches courses in political philosophy and American politics and has won several awards from Berry for doing so.

He is executive editor of the acclaimed quarterly journal, Perspectives on Political Science, and has been chair of the politics and literature section of the American Political Science Association. He also serves on the editorial board of the new bilingual critical edition of Alexis de Tocqueville’s Democracy in America and on the editorial boards of several journals. He is a member of the Society of Scholars at the Madison Center at Princeton University, the George Washington Professor on the American founding for the Society of Cincinnati for the state of Georgia, and he is a member of President Bush’s Council on Bioethics.

He has written or edited ten books. His newest book, Aliens in America: The Strange Truth about Our Souls is a starred, featured selection in Booklist, the journal of the American Library Association. Another recent book, Postmodernism Rightly Understood, was also widely reviewed and praised. His very long introduction to a new edition of Orestes Brownson’s The American Republic is now available.

His American Political Rhetoric (edited with Robert Schaefer) is used in introductory American government courses at a sizeable number of colleges and universities. The fifth edition was just published.


Some of the topics of his recent articles and chapters include Shakespeare’s The Tempest, William Alexander Percy, Walker Percy, Alexis de Tocqueville, biotechnology, bourgeois bohemian virtue, religion and conservatism, compassionate conservatism, conservatism, the filmmaker Whit Stillman on nature and grace, disco and democracy, Casablanca and the American dream, the future of human nature, the utopian eugenics of our time, the rise and fall of sociobiology, Richard Rorty, grade inflation and the Ivy League, Harvey Mansfield and Carey McWilliams, caregiving and the American individual, Christopher Lasch, virtue voters, culture wars, Flannery O’Connor and nihilism, Orestes Brownson, and postmodernism rightly understood.

Lawler has given invited lectures at more than 50 colleges and universities. He has received a large number of grants from both the Liberty Fund and the Earhart Foundation, as well as numerous other foundations.

Paul McHugh, M.D.

Council Member

Paul R. McHugh, M.D. is the University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine. He was the Henry Phipps Professor of Psychiatry, Director of the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine, and psychiatrist-in-chief at the Johns Hopkins Hospital from 1975-2001. He is the author of 4 books and more than 150 papers.
DIANA J. SCHAUB, PH.D.

COUNCIL MEMBER

Diana J. Schaub is a professor and chairwoman of the department of political science at Loyola College in Maryland. From 1994 to 1995 she was the postdoctoral fellow of the Program on Constitutional Government at Harvard University. In 2001, she was the recipient of the Richard M. Weaver Prize for Scholarly Letters. Ms. Schaub has taught at the University of Michigan at Dearborn and served as assistant editor of the National Interest. She has her A.B. from Kenyon College, where she was elected to Phi Beta Kappa, and an M.A. and Ph.D. from the University of Chicago. She is the author of *Erotic Liberalism: Women and Revolution in Montesquieu’s "Persian Letters"* (1995), along with a number of book chapters and articles in the fields of political philosophy and American political thought. Ms. Schaub’s work also appears in the *New Criterion*, the *Public Interest*, and *The American Enterprise*.

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Carl E. Schneider, J.D.

Council Member

Carl E. Schneider is the Chauncey Stillman Professor of Ethics, Morality, and the Practice of Law, and is Professor of Internal Medicine at the University of Michigan. He was educated at Harvard College and the University of Michigan Law School, where he was editor-in-chief of the Michigan Law Review. He served as law clerk to Judge Carl McGowan of the United States Court of Appeals for the District of Columbia Circuit and to Justice Potter Stewart of the United States Supreme Court. He became a member of the University of Michigan Law School faculty in 1981 and of the Medical School faculty in 1998.

Professor Schneider has written extensively on bioethical issues, the law of bioethics, family law, constitutional law, professional training, and professional ethics. He is the author of *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford University Press, 1998), a study of the way the authority to make medical decisions is and should be allocated between doctors and patients, and is the co-author of *The Law of Bioethics: Individual Autonomy and Social Regulation* (West, 2003, 2006), a law school casebook. His family law casebook, *An Invitation to Family Law* (West), is entering its third edition. He is currently writing a book on the law regulating medical decisions of all kinds – especially contemporary and prospective decisions and decisions by competent patients and for incompetent patients. He is also engaged in research on consumer-directed health care, research supported by a Robert Wood Johnson Investigator’s Award.

Professor Schneider has lectured, taught, and published in several countries. He has been a visiting professor at Cambridge University, the University of Tokyo, and Kyoto University, has taught for many years in Germany, and was a visiting professor at the United States Air Force Academy in the winter of 2007.