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Meeting Transcript

September 11, 2008

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The University of Chicago

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SESSION 1: ETHICAL QUESTIONS IN THE REFORM OF MEDICAL CARE

CHAIRMAN PELLEGRINO: Good morning, good morning.

DR. ROWLEY: Good morning.

CHAIRMAN PELLEGRINO: And good morning again. Thank you, Janet, but that's one way of getting attention, just say something. Thank you.

Welcome to the Thirty-Fourth Meeting of the President's Council on Bioethics, and welcome back from your summer holidays. I hope you all had a good one.

I want to take the first step, the official step, of recognizing the designated federal representative, Dr. Daniel Davis to my left. This gives us federal stature and legitimation, I gather, as well, and we're glad to have you with us, Dan, as if we could do anything without you.

I want to also welcome two new members of the Council — I will only provide their names at this point. Background material is available elsewhere — Dr. Jean Bethke Elshtain on my left and Dr. Donald Landry on my right — no reference, I suspect, to your positions. That just happens to be accidental. So we expect you to cover the waterfront.

This morning we pick up a subject we've been discussing on a number of occasions, and it has now been put into the form of an initial white paper. The subject and purpose has been to examine the ethical issues involved in health care policy formulation. The word *reform* was a little bit too ambitious, but rather where should be going at this point in our history with reference to health care which I need not point out is a subject of enormous interest to the American public at this particular time.

Our aim is not to enter into a comparative study of any of the plans being put forward, but rather to step back and look at the ethical problems that should be faced by any plan and which might be used to examine and look at and judge any one of the plans as they're being discussed in the public arena today.

The procedure we follow will have two of our Council members have been asked and graciously accepted the invitation to open the discussion: Dr. Rebecca Dresser and Dr. Diana Schaub. I would like to ask Dr. Dresser if she would be willing to begin the discussion. Rebecca?

PROF DRESSER: Sure. I think that the paper does a good job of showing why viewing medical care as either a commodity or a right doesn't tell the whole or the best ethical story. At the same time, I wondered whether we had to present it in an all or nothing framework. I think that I like the idea of showing that medical care is an essential element of the common good and that's the most defensible way to conceptualize it. But I don't think it would hurt to kind of acknowledge that the other two views do have an influence and play a role in how people think about this, and we can do this without undermining the basic position.

So perhaps we could say that they underlie certain popular ideas and judgments; for example, that no one should be without, at minimum, emergency care. If someone is hit by a car, that person has a, quote, *right* not to be left in the street to suffer, just kind of an ordinary understanding of that, and that on the other hand it may be okay to see some kinds of, quote, *medical care* as a commodity, frills like cosmetic surgery or even LASIK or something like that. So that's just a small comment on the framing of the analysis.

And then a little bit of substantive comment. When I think about this problem, I see that there really is a pretty good general public ethical consensus that everyone ought to have at least a decent minimum of health care — that was the way the President's Commission put it in 1983 — and that this view can be defended using all kinds of different ethical arguments.

So the question then is, why haven't we been able to put this general sense into practice, into policy? So I was thinking about maybe we could call it the hidden ethics of health care reform like we talk about the hidden curriculum in medical school where we teach all these things, but then the students observe how people really behave and learn a lot of often negative lessons.

So if we look at health care reform, one problem would be for many people in the current system health care is a commodity, not necessarily the patients but for the other people who are the players like industry and hospitals and some physicians. So people who, in the current system, who benefit from that and have kind of a stake in the status quo, a financial stake, and their self-interest at stake prevent change from happening or work against it.

We also see physician groups who are concerned about loss of income and freedom. For example, there is a fair amount of opposition to sort of making medicine more restrictive based on evidence-

based judgments. And I agree there is some merit to that, but they're kind of fighting against any kind of restriction that might come with a broader health care plan.

And often the interest groups kind of portray their views, present their interests, as if they are protecting the patient's best interests. So when you think about that Harry and Louise advertising campaign where the insurance companies were trying to protect their turf, but they pretended it as something that put patients at risk, and that was very persuasive.

And then another barrier to change involves two patient interests, so people like us who have good health care coverage may have to accept something less so that more people can be covered. For example, the current employer-based health system has some unfairness in it, especially this failure to tax the benefit as income, and we all get a subsidy from that and it's probably unfair because people who don't have that coverage don't get it. But then on the other hand, as a former cancer patient, when people talk about putting all this stuff into the individual insurance market, it makes me nervous because I wonder whether I'll be able to buy something, a plan, that's affordable and has decent coverage. So I think those dynamics are preventing change from occurring, too.

I think the paper discusses this implicitly and how you would just encourage bringing it out. When we think about medical care as a common good and a public good, we should talk about perhaps sacrifices or commitments that are needed to remedy the lack of access and to generate the political will to get something done.

On Page 34, you talk about public health as a social good, and this is a quote. It says, "Sometimes, public goods, such as protection of public health, require individuals to make sacrifices that will not benefit them directly as individuals," and then it goes on to talk about quarantine and an earlier part talks about vaccinations. So I wonder if there would be a way to just talk about some individual contributions or commitments that the haves can make so the have-nots can benefit, and not necessarily in a preachy way but in a way that might make people want to make a sacrifice as we see sometimes in social life, and then also the contributions that we should expect of business and the medical profession in order to create a care system that really better meets our ethical responsibilities. Thank you.

CHAIRMAN PELLEGRINO: Thank you very much, Rebecca. I think we will move to Dr. Schaub's comments and then open it up to general discussion of the Council. Diana?

PROF. SCHAUB: On the assumption that criticism will trigger more discussion than praise will, I have scoured the draft for things to which I might object, and I have come up with a couple.

Before reaching the conclusion that "it is imperative that the United States ensure that all of its citizens have access to medical care when they need it," the draft report sets itself against two contemporary views: health care as a commodity, and health care as a right.

In the section that rejected treating health care as a commodity, I very much appreciated the exploration of the moral meaning of the physician-patient relationship. While I understand that there are unique features to this relationship, my sympathy for the approach actually comes more from my sense that there are similarities between the doctor's profession and my own profession of teaching. The pedagogical enterprise is also being damaged by consumerist notions. It seems to me that the wonderful description of an ethic of *beneficence-in-trust* is applicable to the profession of teaching as well. Indeed, that it is applicable to each and every profession. Socrates said as much in the *Republic*. What we call a profession, he called an art, and he often used medicine as the paradigm of an art. Thus, Socrates asked: "Isn't it the case that the doctor, insofar as he is a doctor, considers or commands not the doctor's advantage, but that of the sick man? For the doctor in the precise sense was agreed to be a ruler of bodies and not a money-maker."

So like our draft, Socrates insists that medical care is not a commodity. However, Socrates goes on to argue that, because the doctor pursues the advantage of the patient rather than his own advantage, another art must be superadded to the medical art: namely, the wage-earner's art. The medical art produces health; and the wage-earner's art, wages. The individual doctor must attend to both arts. So, I would agree that it is right to resist viewing medical care as a *mere commodity*. However, to the extent that the problems we currently face are largely financial problems (how to pay for medical care), then we need to talk forthrightly about the wage-earner's art and the marketplace.

I'm not quite sure how stressing this moral dimension of medicine helps solve our current problems unless we want to recommend a return to a much earlier, sort of village model of care where doctors as doctors simply provided care to all within walking or riding distance. Those patients who could pay did; and those who couldn't, didn't. With the advent of the middlemen — the private insurers,

the employers, the government — the wage-earner's art has ineluctably become more prominent, and it just seems to me that we have to face that more forthrightly.

I am a little worried that this high-minded distaste for the grubby business of gain results in some problems in the final section of the draft. The text speaks often of ensuring *access* to medical care. This seems to me something of a misuse of the term. When African-Americans were denied entrance to public accommodations like restaurants and hotels, legal reforms were necessary to ensure equal access. The word is used in a very different sense here. The text mentions that with respect to education, we "provide access to all citizens." Well, *access* in that case means taxpayer-funded universal schooling. What does *access* mean with reference to medical care? The text asserts that federal programs like Medicare and Medicaid *provide access* to medical care for the elderly and poor. Wouldn't it be more accurate to say they pay (or partially pay) for medical care? Is the problem of the uninsured most accurately described as a denial of access? In fact, as the report acknowledges, emergency rooms are required by law to treat all comers. I understand that the emergency room as first and last resort is not ideal care. Nonetheless, lack of medical insurance is not the same thing as lack of access to medical care. And, remember, we were told that one-third of those without insurance earn over \$50,000 a year. I take it that they are paying out-of-pocket for routine medical care and, perhaps foolishly, hoping and praying that nothing worse happens.

So the draft tries to make the case that medical care is an element of the common good. I'm not sure that I've been persuaded of that, at least not by the terms used here. In some respects, I think it's actually easier to make the case for health as a public good or a mixed good, than it is to make the case for medical care.

Think about the Spartans. They took great care for the health of women. They imposed exercise and diet regimens, since it was women who bore the next generation of Spartan warriors. Medical care didn't much interest them. The medical care for the diseased and vulnerable, they didn't pay much attention to and they tossed the weak infants off the cliff.

Now I'm not suggesting that we adopt the freedom-denying and brutal practices of the Spartans. However, as our colleague, Ben Carson, has pointed out many times, the right kind of preventive care may contribute greatly to the common good. It may be better and cheaper for both the individual and society to prevent diabetes than to have to treat it.

So it's less clear to me that this narrower category that we're calling *medical care* is an element of the common good. The only real argument offered runs as follows: "Ensuring that medical care is provided to those who need it fosters a sense of community and of security." Now I suppose that those who receive an assurance of care, of cost-free care, will feel more secure, but I'm not at all certain that an expansion in our medical welfare policy would foster community. And, even if it did foster a sense of community, I don't know how that effect creates the prior obligation. Joint action to ensure the social provision of a variety of other goods, including private goods, might foster community too.

So as might be apparent, I am heading toward a dissent from the draft's conclusion. The bolded passage on the last page asserts "Our society has a moral obligation... to ensure that its members... have the requisite ability to meet their needs for [medical] care." Why the euphemistic language? What is *the requisite ability* if not a financial ability? How could society guarantee that people will have the ability to pay? How can the inability to afford insurance be transformed into the requisite ability? Beyond that, how can those who have the requisite ability be made to exercise it? I suspect it's not *ability* that is really meant but *assistance*. Society has an obligation to extend enough financial assistance to meet the medical needs of all citizens, in other words to foot the bill for either universal or greatly expanded health insurance coverage.

So despite the attempt to set some prudent limits to this claimed moral obligation, the final formulation sounds a lot like the famous motto: "From each according to his ability, to each according to his needs." The last few sentences of the draft assert that the Council takes no position on the policy question. However, the way the obligation is stated seems to me to prejudice the policy debate.

And if you'll allow me one final remark: I was pleased to see the summoning of the ghost of Jefferson who made the case for education as an object of *public care*. I did, however, want to argue for the reinstatement of the words that were excised from the Jefferson quotation. In the place where the ellipses now stands, Jefferson says: "not that it would be proposed to take its ordinary branches" — in other words, the ordinary branches of education — "out of the hands of private enterprise, which manages so much better all the concerns to which it is equal." So though Jefferson spoke of education as an object of *public care*, Jefferson was not a centralizer. Moreover, he clearly states his

view that a Constitutional amendment would be necessary for education to become a public care, since education is not among the original objects enumerated for public moneys. Similarly, it seems to me, it's not a sufficient constitutional argument to appeal to the *general welfare* clause of the Preamble as the draft does in making the case for public provision of medical care.

Of course, we as a nation seem to have almost completely abandoned Jefferson's strict constructionism. Still, I think if we're going to cite him, it might be good to give a sense of the whole package: Yes, the public cares, but private enterprise usually delivers that care best, and whatever portion of care government does assume had better have explicit constitutional warrant.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Schaub. Before opening to a discussion, I have to make an announcement. We've been asked by the audio specialist people that those of you who have Blackberries inhibit the use of the BlackBerry during the meeting because they interfere with the transmission. Am I correct about that? It has nothing to do with my feelings about BlackBerries. It has only to do with the technical question of transmission. So I hope you can help us on that. I may have to make that comment a little bit later.

Before opening it up to discussion with the Council, let me point out that we have two of the members of the staff who have made the initial effort here and presented it. I will reserve any comments they may have after the Council has had a chance to discuss the paper.

We're now open to those of whom would like to comment. For those of you who are new members, a signaling of the hands and we'll keep you in order. Everybody will be given a chance. Dr. Elshain and Dr. Carson?

PROF. ELSHTAIN: Well, I want to, first of all, thank our members who made such interesting presentations and very helpful ones indeed. Reading this draft over, it seemed to me that what it was attempting was to answer the question, what is the best sort of ethical narrative that we can offer about medical care and health care? They're not identical, the question of health and the question of medicine, as the paper makes clear.

When you evoke the language of the common good, that's tied to a whole cluster of assumptions about the nature of society, the role of the state, the role of civil society, and indeed the nature of the person, himself or herself.

Now those were not very much argued out in the paper. I mean, it's a limited paper. But, still, it is tied to these kind of presuppositions, so if I may just say a little more about that.

The two narratives that were found problematic also, of course, begin with certain assumptions about the individual, whether you're talking about medicine as a commodity or as a right. In the one case, the assumption about persons in the commodity narrative is that we are primarily maximizers of our own utilities, that we're rational-choice agents, and that we will see to our own best interests at every turn.

The rights model, although it gets complicated given the very interesting discussion of negative rights or immunities and entitlements, rights as entitlements, but, that said, assumes a or has come to assume in our time a kind of Comitian autonomous self who is busy exercising her rights at every turn and often sees these rights as in conflict either with what society is doing or with somebody else's rights.

Now when you get to the common-good notion, the assumption is that we are all intrinsically social persons, that we all aspire to live together in relative harmony and decency with one another, and that we all, therefore, are prepared to bear one other's burdens up to a certain point at least.

So I think one of the questions I had is, looking at American society today, how indeed do we think of ourselves? Do we think of ourselves in the way that the common-good argument presupposes? How strongly can you press that?

And I have a suspicion that most Americans are an interesting amalgam of all three of these, all three of these perspectives when it comes to how we think about persons. That makes the task, I think, undeniably difficult. If all people thought of themselves in the way the common-good model presupposes, it would be much easier to agree to certain statements and then to see certain policies follow therefrom. But we know that it isn't or we would have resolved this issue in some way that satisfies at least most of the people most of the time by now, but we haven't resolved it. So I think in a sense the paper alerts us to why, at least some of the reasons, for why we haven't done that.

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

DR. CARSON: Well, congratulations to the staff for trying to at least put this into some type of a logical format because it's a very difficult thing to do, you know, given the fact that we live in an American society where there is — basically, it's a capitalistic society in which great emphasis is placed on personal responsibility. Now that is in direct conflict with a society that says everybody should be taken care of with regard to their health care needs regardless of circumstance.

So we have an inherent conflict set up there, and I think that's one of the reasons that we're having such difficulty resolving this issue. And I've thought about it a lot, and it's very difficult to come to the right conclusions.

I was giving a deposition this week in a medical malpractice case against some obstetricians who obviously had done nothing. But thinking about the poor kid who was involved who has substantial medical needs, we live in a society that doesn't have any other mechanism for taking care of that child which then spawns an abusive legal system that wreaks its own set of havoc, not only on the medical profession, but on society at large.

So clearly we need to design a mechanism that allows for basic care to be given as is in the case in virtually every civilized country in the world except ours, but one that is insulated against the abuses of sluggards and people who expect to be taken care of unless we are willing to relinquish some of the basic tenets of our society.

CHAIRMAN PELLEGRINO: Thank you very much, Ben. Further comments? Dr. Elshtain?

PROF. ELSHTAIN: Well, can I just piggyback off what Dr. Carson just said? It was another of my notes, a point I wanted to get in, and that is the whole question of responsibility. The paper marks up to that issue and discusses some analogs, what we expect from people, what they're obliged to do in order to have access to this kind of good. But it doesn't specify, the paper doesn't specify, very much by way of what we expect from people for their own health, their own well-being.

So if in a sense — I mean, I don't think you can avoid this. If we say society is going to be responsible as a whole for people's medical needs and then we have the health issue looming there, too, then what is the individual's responsibility where self-destructive behavior is concerned because we know very good and well this is likelihood to lead to this? Society bears the whole burden. Well, where does the individual's responsibility fit in?

And I think Dr. Carson is right. That brings us at some point right up against our notions of liberty and I can do what I want with myself and John Stewart Mill's argument about self-regarding and other regarding actions and all the rest of it. And I don't see how we can avoid saying more about that.

CHAIRMAN PELLEGRINO: Dr. Meilaender?

PROF. MEILAENDER: I have some questions about the structure of the argument which I don't think I really understand. For starters, I'm not clear about the distinction between health care and medical care that's made here, and particularly there are moments when the distinction is between health and medical care and then other moments when it's between health care and medical care.

I mean, I do have some understanding that health care is supposed to be a more expansive notion. But nobody thinks that people have a right to health or that we have an obligation to provide it. We have no obligation to provide what is simply not within our power to provide. So the distinction has to be health care and medical care. And evidently we have an — I mean, to me the thing is set up in such a way to say, well, no, we're not making an unreasonable argument as if people have a right to health care. It's just medical care that we're obligated to provide, but that includes emergency, catastrophic, and chronic care and that includes a lot. And the thing is just set up in a way, I think, that the more you press on it, it sort of cannot be persuasive.

So the distinction seems to be no right to health care but an obligation to provide medical care. If we have an obligation to provide medical care, do people have a right to that medical care? I mean, that issue of the correlation between rights and that obligation is never really sorted out and pressed. So the basic structure of the argument, the longer you think about it, lacks the kind of sharpness and clarity that's needed to be persuasive. So that's my one problem with just the structure of the argument. The longer I think about it, the less it works.

And then the other thing I'd just say, with respect to the sort of conclusion in bold print that Diana had one point that she made about it earlier, I'd have a different point.

One always had to control one's rhetoric. The society can, should, and indeed must respond. Well,

once again, the paper has not gone to show that we can. That's an empirical question, and the paper hasn't argued it. And if we can't, then I'd like to hear the argument that we must. So the conclusion may not follow from what's come earlier.

And avoidable human suffering? Well, how do we know what's avoidable along the way? I mean, the longer you press on certain parts of this argument, the less sure you become what it really is. I mean, the structure looks clear at the start, but I can't figure it out when I really go to work on it.

CHAIRMAN PELLEGRINO: Thank you, Gil. Further discussion? Comments? Rebecca, Diana, did you want to add any — oh, I'm sorry. Paul, I'm sorry. You're off to the right.

DR. McHUGH: Not at all, not at all. I find the conversation very helpful because I did find this text very difficult to know where I could stand and fit. It mentions things and talks about things that I agree about and then it draws me into areas where I'm just not so certain.

I like the idea that it is a responsibility of our society to offer assistance to the care of the sick. That is our task. It has been a traditional task in medicine right from the beginning that we would assist people in gaining this care. And so at various stages, hospitals, staff in the hospitals, doctors within that staff would work long hours and not complain too much about the fact that they had to work long hours to accomplish the serious needs of the community to which we were embedded.

Certainly I remember very vividly feeling when I became an intern in medicine for the first time I was no longer taking but was giving to the community in a variety of ways. Of course, it was impressed upon me that I was giving at that time because my pay was \$25 a month even though I was working 110 hours. On the other hand, it was, I have to tell you, one of the happiest years of my life in which I was doing this.

Since then, with the advent of insurance and with the advent of medical care and things of this sort, the capacity for our society to give more assistance in this process has spread from the eleemosynary institutions out to everyone, and I have appreciated in a step-like way the accomplishment of this assistance to people identifying, first, of course, with the Medicare laws and with Medicaid the elderly as a group that was going to need more assistance both from the fact that they would have more illnesses and were more restricted and needed help.

I'm looking for a system that begins to approach this ideal that we have that the care of illness — that's what I'm talking about, the treatment of disease — should be a natural, easily-accessible thing as an ideal. I like the idea of approaching it more asymptotically and seeing on each step along the way what problems have arisen from that, what problems we need to solve at this stage to make that assistance equitable and efficient and the like and before moving on to others.

So I like small bites in this matter rather than large bites, and then I'd like to know what we've learned at each one of the steps along the way to be sure that the process is efficient, the process is equal, the process is truly fair. And I miss that little bit.

I want just to come back to emphasize the idea that with Diana I want to make the point that we're talking about assistance and most of that assistance is financial and some of that assistance turns into service that is not being immediately paid for but given out of the professional commitment and vocation of doctors to care for — and nurses and other people — to care for the sick poor of their community.

CHAIRMAN PELLEGRINO: Thank you very much, Paul. I just want to tell you that you were overpaid because in my internship I got zero. It was bed and board — a little more indenture, I'm afraid. Thank you very much for your comment.

The next on my list is Dr. Janet Rowley, and then Diana will — is it on this point? Go ahead, Diana. Janet, do you mind?

PROF. SCHAUB: A question to Paul. I was uncertain. Initially, I thought you were moving in the direction of saying that the society-at-large should continue to provide more of this assistance and expand the assistance in incremental steps. But then at the end, you seemed to suggest it would be the doctors who would take the financial hit on that older model of the obligation. If there's a moral obligation, it's an obligation the medical profession has. Can you just —

DR. McHUGH: No. I'm sorry. In separating those two, I didn't bring them back together again.

The doctors out of their vocational thing should be giving certain things as they are, as well, expecting that society, too, would join them in giving the assistance that the society does provide.

I think the point of service area is a place where certain kinds of givings go on. And outside in the system, the system has to be construed as a gradually and improving efficient service to the needs of the community.

CHAIRMAN PELLEGRINO: Thanks, Paul. Janet Rowley?

DR. ROWLEY: Well, I first want to say that, by and large, I really appreciated and supported the report as written. And I would like to say that I agree with Paul that there were certainly a number of parts that I felt a bit shaky on going from A to B to C and that they all necessarily followed. So I think that criticism of Gil in some of these areas it certainly needs to be looked at.

I should say that I disagree with Paul that the changes that would be appropriate — and here we agreed we didn't have the expertise to comment on them. But our system is so different from the others that have been shown to be functional in the world, and ours is dysfunctional, so I'm not certain that small incremental changes are going to get us where we would like to be; namely, that less fortunate members of the society, poor or less educated, will actually have available to them the health care that they need.

And I think I'm going to just duck the responsibility. I mean, one can say, "Well, you smoke a whole lot of cigarettes and you get lung cancer, it's your problem, not mine." But then others say, "Well, if you spread those kind of risks over all of society, it's not that much of a burden on any individual." And how one manages that, I'm not certain.

I think I disagree with Gil's concern in the bolded paragraph on the last page about *can* because there are at least a number of economists who say that the amount of emergency care that society pays for for people who have no insurance is pretty horrendous and that if you could use that money to preventive care or at least a certain component of it, you would, in fact, go a long way to covering the cost of universal health care.

And I think that when you look at other countries who have universal health care, they're paying a far smaller proportion of their GNP than we are. So one has to then look back and say, "Well, maybe what we're doing is not very effective and is costing us more than it ought to if we had a different system."

So I think that I support the notion that our society should give better or provide — I mean, I understand your concern with access, but should see that everyone has better health care and can go to the physician at signs of early disease rather than late or even as prevention and that in the long run society is going to benefit from this.

CHAIRMAN PELLEGRINO: Thank you, Janet. Gil?

DR. FOSTER: Could I respond to one of Janet's comments real quickly?

CHAIRMAN PELLEGRINO: I'm sorry, Gil.

DR. FOSTER: Could I respond to one issue here very quickly to Janet? The issue of emergency care is, right now, it's the court of last resort and so forth. But in most big cities and certainly in Dallas what's happened is that shops open for payment in shopping centers and so forth. They advertise on TV constantly. And what they do is that they drag away anybody who is paying for emergency care out of places like Parkland Hospital and so forth so that what's happening is that they're being robbed of any possible payment.

And there are over 300 emergency rooms in this country that have already been — have already closed on this issue. So it's not just the cost. It's the fact that that has been seen as a profitable thing by industry, and so it's going to get even worse about how we're going to take care of these patients.

If you walk into where I work in Parkland Hospital and you go into those halls, all that's there is the wounded of the city who can't pay a dollar. They're not on Medicaid. They're not on any — many of them are illegal immigrants and so forth, and so we've got the problem, not only of the calculated costs of emergency room, but also that that's going to appear to be difficult to sustain.

CHAIRMAN PELLEGRINO: Dr. Meilaender?

PROF. MEILAENDER: Yes. I wanted to come back to my question about the structure of the argument. I'm wondering if I can get an answer from our staff members who are sitting there to a question.

What I want to know is, if I said fundamentally the structure of the paper is to argue that people don't have a right to *health care* but they do have a right to *medical care* as those terms are used in the paper, would that be an accurate description of the argument of the paper?

CHAIRMAN PELLEGRINO: I'd like to respond, but Tom first.

DR. MERRILL: Well, I'll be interested to hear what Dr. Pellegrino says. I think the answer to that question has to be yes. We could talk more about how that might play out in practice, but I think the short answer has to be yes.

PROF. MEILAENDER: Can I just follow up with one thing? Is the structure then not a little deceptive in taking up commodity, right, obligation, it seems to me, because it turns out there is a right to something that's rather considerable?

I'm not arguing about whether it's good or not right now. I just am asking what the question — the question about what the structure of the argument is and whether, in fact, it's laid out in a manner that is less than straightforward.

CHAIRMAN PELLEGRINO: Would you like to respond? Before responding, I'd like to call on Dr. Carson who is on the list. Ben?

DR. CARSON: Well, I think Janet and Dan have talked about something that is absolutely crucial, and that is the enormous amount of waste that exists in our system. As we learned during our last meeting, as a nation, we spend more than twice as much per capita on health care than our closest competitor. And, yet, we rank number 37 in the world in terms of health care distribution. This is a huge, huge problem and really, I think, undergirds a lot of what we're talking about here, the incredible inefficiency that exists in the system, and it's actually getting worse.

When I started practicing medicine back in the old days, if there was an indigent patient who needed to be taken care of, it was never a problem. I could bring them in. You could do a complex operation. You could get multiple consultants. Nobody raised an issue. It was a total non-issue. Never was it a problem.

It was only after the insurance companies began to exert so much influence and power and the ability to say, "Well, I'm only paying this much for this person and this much for this person," that things continued to get to the point where physicians in private practice even now don't have financially the capability of providing the free care that they used to.

Every physician used to provide free care — 10, 20 percent of their patients, no problem. Nobody even thought about it. And we paid less than we're paying now. So I wonder if maybe we ought to ask, what happened? Where are the real culprits in this situation, and how can we address them? Do we have enough courage to actually address the issue where it exists?

CHAIRMAN PELLEGRINO: Any other comments? Well, just a few since Gil has asked me to. I think you did ask me. Did you? Gil?

PROF. MEILAENDER: Well, I directed my question, first of all, to the staff who wrote it. But I'll be happy to hear what you have to say about it.

CHAIRMAN PELLEGRINO: Okay. Well, they've turned it over to me. I think the question here, Gil, was the ethical issue. The question of obligations for health care and medical care might both be defended. I'm not taking that position. But I think what we were trying to deal with here was a priority of availability of resources.

And whenever I talk to any group of people and I ask them, what are the things about your health that you worry most about — and I don't care what station in life they're at — and the first one they say is that some emergency will happen to me, and I would like to have be able to have available emergency care — not that I would like, but I would need emergency care. It's what I call *medicine of rescue*, and that's what the clinician immediately faces. No matter how it comes, Ben, you've got to take care of it. And so the concern I see when I talk to people and I hear is that's the number one that I hear about.

The second one they fear — and this, of course, is not a sociological statistically strong statement but years of talking to human beings about their concerns, certainly the second one is chronic, catastrophic illness. There isn't anyone around this table who's not susceptible to an immediate possibility of a catastrophic health problem. And the question, being if they're able for it and they have the resources available, is of concern to people. So we're trying to reflect that.

I think in terms of ethical priorities then, health care, which is the maintenance of good health if you have it, and the cultivation of better health if you don't have it, is important. But whether it would rank as a right in the same strength as emergency care or rescue medical care, I think, is the question that leads us to separate these two.

Before you respond, let me finish. I certainly, as you know from the past, will give you plenty of chance.

So I think that was the basis.

The second thing is, I certainly believe in preventive care, and there's a kind of fiction around that physicians don't believe in medical care, in preventive care. We do. But, again, it's a matter of priorities. We're faced with people who are in immediate need, who are dependent, who are vulnerable, like your students. Students are vulnerable. They're dependent on us. We can deceive them. If our characters are not sufficient to meet that challenge, we can create serious difficulties. But those things that go into prevention are matters of behavioral change, and they take a long time.

Coming down this morning, some person riding a bicycle that was not aware of the health problem of riding between two rows of cars, swerving back and forth, and he could not be seen by the car that I was driving in and almost went. That would have been a serious medical emergency. He would have needed rescue care.

The point is, it takes a while for preventive medicine. We're, I'm sure, not talking about immunizations and things that can be done quickly. You are talking about those things that have to do with chronic illness, and that's diet, exercise, stress, changing your attitude on life, taking care of yourself. Those take enormous changes in behavior. Time — and I might add, the most expensive kind of care — time put in by one person to assist another person to change her care.

So I'm not making a plea for one or the other, Gil. I'm making a distinction and only a distinction of priority, not of exclusion. So it's not either/or, both/and, but which comes first if I were doing it. Now I did not write this paper, so.

PROF. MEILAENDER: I don't disagree with that way of structuring it, though, I mean, it may be useful to note that a lot of people do. I mean, a lot of the emphasis today is, in fact, on the preventive side rather than that. I do not disagree with you. Indeed, if I never hear anybody use the word "wellness" in my presence, I'll be happy.

But what I'm interested in — and I just repeat — I'm not even yet interested in figuring out what I think about the position we're taking up. I don't think the draft really accurately states the position that's being defended there because we're not setting up three different kinds of things thinking in terms of commodity, thinking in terms of right, thinking in terms of some kind of civic obligation.

What we're distinguishing between is a claim to a right to health care and a right to medical care, and we're arguing that there is a right to medical care. That's essentially what this draft does. And if that's what we want to do, let's write it that way and then I'll figure out whether I do or do not sign on.

But I think the draft is systematically ambiguous and ought not be. That's my claim. It's a claim about the structure of the thing as it stands right now.

CHAIRMAN PELLEGRINO: Yes. I would not disagree with that. I think that that has not been unraveled clearly enough. I did not write this, but I did participate in the discussion. And I think that my colleagues know that I made the distinction that I just made some moments before as an important one.

And the purpose of our presenting this to you, the white paper, is to get the kind of comments you're making now and then they will be incorporated and taken into whatever next version comes out. I'm sure that both Tom and David are listening very carefully to the comments you're making.

I responded rather strongly because I think that my concern as a physician who is still seeing patients is that we have people who are not getting care at the time that they need it because of the system as it exists here today.

And right here in the Capitol City a significant percentage of the population do not have this kind of care, and they need it.

Dr. Landry and Dr. Foster.

PROF. LANDRY: So as a physician, I found that the common-good analysis resonates with our ideals for the profession. But I agree that there are ambiguities with respect to the rights analysis, and you want to salvage part of that when you argue that there's a right for medical care.

I also think in terms of commodities, you have to be careful that you don't construct a straw man and that you give the commodity analysis its best case because I think you're going to need that as well.

If you look at the need for resources, for emergency care, perhaps we know the upper limits as we see CAT scans and MRIs increasingly used at a point of emergency service. In terms of catastrophic care, I suppose we can look at liver transplantation and maybe future combinations of bone marrow and liver transplantation to become free of the need for immunosuppression as sort of an upper limit on what might be done in a catastrophic situation.

In terms of chronic care, I don't think there's any limit to the cost. And whether it's biologics which are coming on line or whether it's advances in personalized medicine and individual analysis at the genome level, the need for resources are enormous.

And this comes to the *can* question. You know what can we do? And so there's going to be, I think, a notion of commodity, but not necessarily one that has to affect the physician. The physician can still operate in the common-good level. The patient may be working at a commodity level. And so here the issue of responsibility is key.

I thought the emphasis on economics was not entirely fair. The issue isn't whether people smoke, but the fact that they use their resources for cigarettes rather than for health insurance. This is a continuous thing. The draft recognizes those with relatively high incomes who are not getting insured. But at every level in this continuum, someone is making a decision and balancing what they want in one area versus what they want in another. So the notion of salvaging some aspect of the commodity argument as you practically implement a program based on the common good is something that I would emphasize. Thanks.

CHAIRMAN PELLEGRINO: Thank you. Dr. Foster? And after that, we'll ask both Tom and David to make some response.

DR. FOSTER: I just want to make two points very quickly in terms of preventive care. There's a great deal of talk about this, but it's a difficult problem in the sense that it's not always personal will.

I heard a lecture by Joe Goldstein on one occasion early on who won a Nobel Prize about the cholesterol and so forth and so on. And he started off the lecture with a picture of Winston Churchill and a picture, side by side, of Jim Fix. Jim Fix was the lean great runner, who did everything perfectly in terms of his health, and he dies when he was about 50 or something like that. On the other hand, Churchill did nothing for his health. He smoked constantly, he drank heavily, and he was massively overweight. And so he lives for a very long time, and Jim Fix doesn't. So there are underlying genetic things that are separate from the behavior itself; now, the most common thing, if you eat less, you'll lose weight. And so I just want to make the point. It's that preventive medicine is not necessarily as simple as it is.

After all, only one out of seven people who smoke constantly get a lung cancer. I mean, so your perspective — in diabetes, overwhelmingly there are people who don't get insulin resistance and Type II diabetes, even though they weigh 700 pounds, and so forth. So it's not a simple thing. This is not an argument. Since I work in diabetes, I spend hours and hours and hours about how-to.

But the second point I want to make is that most of these problems, as Ed points out, are behavioral. And as a consequence, they're very hard to break. I personally doubt that we can ever — you know, the obesity metabolic syndrome, now is not only the leading cause of Type II diabetes but also the leading cause of liver disease in the world, more than alcohol, more than anything else, because of fatty liver, the non-alcoholic fatty liver disease. And I don't think you can change that.

I think the only way to cure it is to do a gastric bypass operation. It's the most amazing thing that if you do a bypass rather than a band — you'll lose weight with a band. But if you do a bypass and take the duodenum out of it, you're cured of your diabetes in two or three days often, and it's permanent. And that's because there are substances being made in the duodenum that block the action of substances made elsewhere in the gut that protect you against diabetes.

So I think it sounds really wonderful to say, well, we ought to work in prevention. But it's very hard to do, and I just wanted to emphasize that point.

I think that the only answer to the Type II diabetes, is you're going to get a drug that does what the

duodenum does, you're not going to do it by will, I don't think — at least I'm pretty persuasive, and I have been largely unsuccessful in getting people without bariatric surgery to get a curative for diabetes. So I only wanted to make that point. I'm in favor of preventive care, but it is really hard.

Let me say one other thing. The system — we do liver transplants all over the country for people who are alcoholics and have alcoholic cirrhosis, and you can say, "Well, they're to blame for this." But right now the physicians and so forth go ahead and treat these people as though they had a liver failure that was not vested in alcohol, and so I don't know whether the medical community is going to say, "Well, okay. This person deserves to have gotten cirrhosis of the liver" or "deserves to have gotten it."

My own view is, I'm going to take care of him anyway. I mean, as a physician, when they come in, I'm going to take care of them. And I don't know whether the implication is that medical care ought to be stopped if somebody precipitated it themselves.

CHAIRMAN PELLEGRINO: I have Dr. Gómez-Lobo and Dr. Hurlbut. If the staff will permit, I'll have them comment first. Dr. Gómez-Lobo and then Dr. Elshain?

PROF. GÓMEZ-LOBO: Okay. I must admit that the draft presented by the staff for me at least was very illuminating in different aspects, although there may be difficulties with certain parts of the argument.

Now what I'd like to say is this. One of the things that impressed me most in the paper was this reference to 18,000 deaths a year that are attributable in part to lack of insurance coverage. And to me it seems or at least I can say this is the way I view things particularly after the Chicago meetings and reading the paper is that universal health insurance should be a goal. I just don't doubt that. I think that the fact that we don't have it and that we have these deaths and that we have all of these other consequences is just bad, and that should be what we should push towards, although maybe we should not go into the way to achieve it, but I think that should be the goal.

Now the objection to that is the objection of responsibility. Should people who are irresponsible in their behavior also be in the system? After what Dan had to say, I would say a resounding yes. Everybody should be in it even though there may be some free-riders in it. But the reason is that, from what I understand, illness is to a great extent not determined by our behavior. There are these things mentioned about Winston Churchill, for instance, who famously was asked, why did he live so long, and he said, "No sports."

So now that said, in other words, I see that goal as important. How I would argue for it, I really would hesitate between rights and the good of society. I would primarily call it a very important good that we should aim at.

Now whether it's convenient or not convenient to treat it as a right, whether it's rational or not rational to treat it as a right, I tend to view as a secondary issue.

And I would like to see the Council — again, it's my personal view — pointing towards that goal because it really — you know, if I compare it to Europe, Canada, and other places, to be in a position of saying that there are 18,000 preventable deaths just because there's lack of insurance, that really is for me immoral, a very serious moral problem. Thank you.

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

DR. HURLBUT: I didn't actually have my hand up. But since you called on me, I'll make a comment. Just one little side comment, not that most of what's been said is more central, but there's just one little dimension of this that I think we ought to keep in mind, and it was evoked from me when Dan was talking about this — and Ben, too — talking about traditions of medicine and the feeling that the physician has an obligation to the patient.

It's just absolutely central to medicine that we emphasize that we do not judge the patient before us in a critical way, that we understand that everybody's life is difficult, involves a circuitous path towards where they are at the present, that none among us is living this morally virtuous life that allows us to be free of cause of our own corruption of body and mind, that the truth is, that human beings are imperfect and when we have a patient before us in need, the patient comes before us and we deal with the patient as a profession with an implicit forgiveness and compassion.

But the thing that I want to bring out in that, and I really want to underscore what Ben said. I grew up in a household. My father was a physician, and I grew up in a household very conscious of these needs. My own father gave two afternoons a week of his life to care for which he got no

compensation.

And I think it made his whole professional life mean a lot more to him, especially because he wasn't getting compensated by the government for it. It was something about it that it evoked in him a sense of the purposefulness and nobility of the profession he was part of, and that spilled over to me. And it was one of the main motivations. I think those two afternoons affected my decision to go into medicine more than the rest of his week did.

But this is what I want to say, and it's just a small piece of the puzzle and it doesn't override what anybody, Alfonso or anybody, said. Whatever we do, we've got to keep in the equation the sense that where medicine is not a commodity or a consumer item or a contractual matter or where it's not a right, where it becomes an ethical dimension, there is something in that ethical equation that needs to issue forth freely from those who give. This used to be expressed by the individual physicians, by the community hospitals having bake sales, and a general sense of social obligation playing out.

Now it's gotten strangely removed all the way up to the top levels of the federal government. And I'm not saying it shouldn't be there. I just don't really know completely. But whatever we do, we've got to remember that ethical obligations require the assent of the ethical heart or spirit of those who give them. And whatever we do, let's keep that in the equation if we can.

It's a small comment, but I think it's a part of something we need to remember.

CHAIRMAN PELLEGRINO: Thank you very much, Bill. Dr. Elshtain?

PROF. ELSHTAIN: I always hesitate to put this question after listening to these very eloquent characterizations of the medical profession as a profession that really professed something and was able to enact that profession at least at a certain point in time.

But clarification from the staff is what I'm interested in. I know, again, that this paper is not a policy paper as such. But apropos the discussion we've had, I'm wondering if you would consider that the sort of common-good obligation, which I understand is not a perfect obligation, but an imperfect one — be that as it may — the common-good obligation would be met if everyone in the society, in this society, there was a baseline of coverage; that is, that no one was to fall beneath a certain level as far as medical care is concerned, but that that would be — exist, in tandem with, other forms of care and medical and health provision that would be accessible to those who have greater means or those who have greater coverage, coverage plus.

And I ask that because the societies that are often held up as salutary alternatives to our own actually do have something like that. I mean, if you look at England, for example, those who have the means, many of them, opt out altogether, as you know, of the national health and go through BUPA through the private association of British physicians; Canada, the same.

So what kind of system are you imagining and what levels of care that would satisfy the common-good criterion?

CHAIRMAN PELLEGRINO: Thank you. I'll give the staff a chance to respond calling to attention that there is a time limit. We finish at 10:30, since we have a pretty packed agenda for the rest of the day. So, Tom or David, whomever which?

DR. MILLER: I do have a few comments. In terms of the common good and negative rights or positive rights, I don't know that saying that a society has an obligation, a moral obligation, to ensure that health care is provided is necessarily the same thing as saying that people have a legal right or a legal claim to medical care. And so I know that Tom did say that we're saying there is a right to medical care.

Instead, what I would say is that it's an element of the common good — there are a variety of elements of the common good — and that right now we require medical emergency care to be provided by emergency rooms. And the financing of that is done in this complex way in which for some uncompensated care money is providing by the government. It's provided by raising everyone else's costs, et cetera. It's a very complex cost-shifting mechanism.

To make that more transparent or more apparent would help us to see how are we already providing resources for this and, if we can look at that, what portion of our resources are we willing to commit to this good? That's not to say that there's an unlimited right and that everyone that comes in has a claim to unlimited medical care. It is to say as a society, "What are we willing to provide for this?" Right now, it's this sort of shell game of costs, and I think that that needs to be made clearer.

And I think that, therefore, to say that it is an element of the common good and to say that it's something that we need to assure people have access to is not necessarily to say it's a right. And it's also not necessarily to say that any particular system is going to do it.

So there may be a two-tier system or a private-public system or we may just find that different programs, even the tax-rebate programs and shifting insurances, all of these are attempting to expand the coverage in some ways. Whether they will or will not is something to be determined. But what we want to say is that that needs to be done and that there's a moral imperative to move in that direction.

I guess I wanted to say two other things quickly. One is the relationship of medical catastrophe to financial catastrophe. I think that part of the concern that people have with having a medical emergency is that it will wipe them out or bankrupt them. And that's the way in which medical care is connected to security and to people feeling that they have a sort of sense that the community will take care of them. I think that the common-good conception should try to capture some of that.

Finally, in terms of responsibility with Prof. Gómez-Lobo's comment, I do think that it's — I don't know whether this paper should address it or whether we need to address it at some point. But there is this tension with responsibility. And in some ways the tension is captured in that rights versus commodities piece.

The commodity section really says people are responsible and they should spend their money as they want, and that's how they exercise their responsibility. In the rights talk, it's really people in some ways don't have responsibility. It's a right to have a claim regardless of what they do.

And so this is where the common good is trying to pull those two pieces, pull from each piece, and say there is an element of each, recognizing this conception of the common good and recognizing the goods that would be advanced by that.

So I think that's what we were trying to do, and maybe we need to do it more carefully. I also think if we do discuss responsibility there is an important element, not only of the genetics, but also of the social determinants of responsibility and the ways in which people are, not to say their communities determine their behavior, but to some extent, the way in which people are raised, the way, not only what they're fed as infants and as their growing up, all of those things determine the choices that they will make and in some ways influence that so that holding them to these high moral things saying that they're smoking, yes, they are choosing it. In some ways their choices are shaped by the ways in which the communities in which they've lived, the ways in which they've been raised, et cetera. So there's that balance that needs to be addressed as well.

And actually I think I will write to Diana Schaub and tell her why I put that ellipsis there. But, briefly, it was, I think, that Jefferson in that quote was saying, when he said that education ought to be provided by the state, to some extent he was saying there were some pieces that wouldn't be provided by private education itself. And so I thought that that would sort of distract.

I was going to put it in and put a footnote and say, "Well, there may be elements of education that the market wouldn't encourage, and there may be elements likewise in medicine that are not covered by the markets so that the market may not necessarily lead to the best distribution and actually help those people who are unable to make their way into the market at all." But I can talk to you about that. Again, that's all. Thank you.

CHAIRMAN PELLEGRINO: Thank you very much, David. Tom? By the way, I'm being very familiar with these gentlemen. They both have Ph.D.s and I should be addressing them as Dr. Merrill and Dr. Miller. But we work together, so sometimes one slips into familiarity. But I don't want you to believe that they're not as qualified as — maybe more than I am on this kind of thing. Dr. Merrill?

DR. MERRILL: I think the question of whether or not there is a right is a big one. I don't have anything else to say about that.

I will respond to Prof. Elshain who asked whether a two-tier system would be appropriate given the ethical model that we see here. And I certainly won't claim to speak for the entire staff. My sense is that it would be appropriate that any conceivable reform that we're going to see in the near future is going to look something like that. And so that's a question for way down the road, if ever, in the American political conversation, not to say that it's not an important question. But that just looks to me where we are.

Are we willing to say to people, "Well, you have to carry at least catastrophic coverage?" Is that an illegitimate infringement on individual liberties? I think that's a kind of ethical question. And part of

me is tempted to say, "Well, of course, we would be willing to do that. We do that with car insurance." But it's actually a pretty complicated thing. Health care is a lot more complicated than cars, and there's a lot of different ways that you could play out that analogy.

It looks to me like that's going to be the big question on the health care front in the next five years, say. And I don't have an answer to it. I just think that's it.

PROF. ELSHTAIN: Can I just do one quick policy?

CHAIRMAN PELLEGRINO: Thank you, Dr. Elshtain.

PROF. ELSHTAIN: Just a quick policy for one minute, one minute and no more.

CHAIRMAN PELLEGRINO: Okay, yes. Go ahead.

PROF. ELSHTAIN: And that is, I know that inside both campaigns at this point, whatever the candidates are saying, that the Massachusetts plan is being taken as a kind of template on which any possibly viable system could be based, so.

CHAIRMAN PELLEGRINO: This might be a time just to make a quick comment on how we function. I said when Gil asked me a question that I had not written this. I was trying to point out that the words were not mine, that I was not going to try to use those in defense.

But Dr. Davis and I participate with the staff on every one of these drafts, so that we're not distancing ourselves from them but indicating that each of us is an individual and have a somewhat different take on these very, very crucial and difficult problems. So I just wanted to the Council to know that.

We have a high degree of independence, but nonetheless when we present it to you it's something we have all looked at, and I don't distance myself from the analysis, but I look at it perhaps a little bit differently in terms of emphases, being human, and having different kinds of experiences.

Are there any other comments or questions? We have about five minutes more. Who is that? Dr. Foster?

DR. FOSTER: It's me, yes. When Janet and I were at breakfast this morning, both of us said — and she said it publicly, and I want to add my comment to it, too — that we thought this was a very good white paper, and I think the discussion this morning, exempting myself, has been very good, the questions that have been raised, and be helpful to you in the summaries there.

But I think this is maybe one of the best. I've read all these white papers for seven years and so forth. And I think this is probably the best and most succinct effort that we've ever put out, and I personally like — I don't know anything about ethics or philosophy and so on, but I like the good, the common good.

So really what I'm saying is I think this has been a really good job, and I want to compliment everybody's comments. I haven't heard a single comment around the room — I usually disagree with a lot of them, and I thought they were really good. So I'm complimenting my colleagues on the Council, but also this, what I think is — and it will probably be stronger after this conversation today.

CHAIRMAN PELLEGRINO: Dr. Rowley?

DR. ROWLEY: Well, can I just chime in and say that I think that, moving this ahead, I realize that there is sort of a queue, if you will, of papers and you've described what the timeline is.

But it seems to me that in respects this has an urgency partly due to the political situation where it maybe should go to the head of the queue and be released because I think that the whole emphasis on health care is, "Well, look at how much it's costing and how much it's projected to rise. We can't possibly afford to do this," and I think that the emphasis on the ethical issues here and the moral issues are those that have been ignored and it should — that should be dissociated from how it's done and part of the failures in the past is how people intended to go about it, and that's where I took exception, if you will, to Paul's incremental change.

I think our system is so flawed that incremental change is not the way to do it. But then you get everybody opposed, which is the deadlock that we've been in for quite a long time. But I think this has urgency.

CHAIRMAN PELLEGRINO: Thank you, Janet. I think it's important for you to say that because

we have all along wanted to emphasize the ethical issues that people might look at as an educational venture, obligation, that the Council has, certainly, not to get into the specific programs, but rather, "Here is a template of questions which we think have ethical importance," and they have not been raised very significantly or certainly widely. That's why we took this in the first place, and that surely has been the way we tried to look at it.

One finds it difficult, having made these kinds of statements, not to get sucked into how do we pay for it and how do we organize it? And the only thing I would submit is that, if we could get our view of what the ethical requirements are fairly straight, we can answer those questions better.

Dr. Carson, I thought the time was up, and I didn't give you a chance.

DR. CARSON: No problem. Janet has stated very eloquently what I was feeling about the urgency of this situation and the need to put it out there, you know, during this current presidential debate. But I just wanted to add one other issue.

And that is, if we are ever going to be talking about a system where anybody who needs medical care will receive it and we as a society have an obligation to provide it, then we need to understand that we will have a system in which no one will pay, because why would you pay if you're going to be taken care of anyway? That would be foolishness. So all paying would cease, and it would become a society of subsidized programs. We need to state that, I think.

CHAIRMAN PELLEGRINO: Ben, that's the next debate. I think we have come to the end of this session. We will reassemble at 10:45 to pick up another difficult question. Thank you.

SESSION 2: CONSCIENCE AND THE HISTORY OF MORAL PHILOSOPHY

CHAIRMAN PELLEGRINO: Our next topic is the topic of conscience and its place in health care and medical care today, particularly the question of the conscience of the health professional and health care institution. In light of the growth and emergence and almost absolutization of patient autonomy, how are the two to be balanced? And what is the present status, both legally and morally, of the sanctity of the human conscience? Should the health professional be morally neutral as some have said?

To start this discussion from its groundwork of the history of the conscience and definition of what it is, we've asked Dr. John Paris, the Walsh Professor of Bioethics in the Department of Theology at Boston College. Dr. Paris has been a friend of mine for a long time. I'm not going to give an extended discussion, but we've asked him to address the fundamental issues while others will pick up the more recent issue of relationship to the health profession specifically. John?

FR. PARIS: Thank you very much, Dr. Pellegrino. As he said, I've known him for years, worked with him at the Kennedy Institute, worked with him at the Center for Clinical Bioethics at Georgetown, and have been a great admirer of his work for many years.

So when he called, he called with a very open discussion, "I'm going to make you an offer, and you cannot refuse." Now it wasn't an offer that I would willingly refuse. "So whatever you're doing, you have to do this because this is an important issue." And I said, "Oh, Ed. What is this great issue?" "Conscience." "Oh, *MON DIEU!* That's not my field of expertise." He said, "No, but you're going to do it."

Conscience is a word we all use, and it's not very well understood. Despite the fact that there is an enormously rich, complex history to it going back into the ancient Hebrews, into the ancient Greeks, all through the medieval period, the focus that I'll have — and some of you will wonder why this is so particularly oriented to Catholic theology, and that's because that's where the development has been very sophisticated and very nuanced in its assessment and evaluation.

But before we begin that, I think it would be important to see why we need conscience. And the best way into contemporary culture, I think, is through film, and two films that we saw in the Academy Award winners this year, *No Country for Old Men* and *There Will Be Blood*, point out the issue of the role of conscience.

In the first of these, *No Country for Old Men*, you know the psychopath goes around and kills everybody with his bolt gun. He's seeking some money. That \$2 million was stolen, and he's after it, and he goes and kills anybody who gets in the way. And there's no remorse, there's no regret, there's no reflection, there's nothing. This is the psychopath who has no concern or consideration for anything but the goal he wants to achieve.

Equally dark and equally neolithic is *There Will Be Blood*, and there you have the protagonist in Plainview blinded by greed. He wants money, and he will do anything to obtain money. One of the workers — he's in an oil field. One of the worker's sons is killed, and he adopts him, not because of any empathy for the child, but because he sees this as the way of getting sympathy and selling his product better. In fact, when the boy suffers an injury and is nearly deaf, he sends him off to a school for the deaf. And later when the young man comes back to see him, he says, "You have nothing in me. You are nothing but a bastard in a basket. Get out." The only thing this man wanted was wealth, and he would do anything for it — throw out his adopted son, murder — it didn't matter.

And what you see in these two is the absence of what we call *conscience*. There was no reflection. There was no sense of right and wrong. There was no sense of regret. There were no moral values other than self-interest.

Conscience is that process by which we reflect upon life and ask, "What is it that I should do, not because somebody else wants me to do it" — and here's one of the counter-distinctions about conscience, not to be confused with the super-ego, that psychological theory of guilt. The super-ego is imposed on us by the ego of others, parents or families in saying "don't do this," "don't do that." We do it to children to protect them from injury. But it's always other-directed. Conscience is an inner-directed sense of growth.

Where does it come from? How does it form? What's its basis? Well, part of it is that we understand ourselves as moral entities. We understand ourselves as entities who have freedom, who can make choices, and these choices are not arbitrary. We determine them for some purpose, and the purpose is that they would achieve some good, that they would avoid doing some evil.

These are internalized values. They're acquired values. And the way in which we acquire them and achieve them is varied. And there are whole world views, there are religious views, philosophical views as to understanding this. And the way I'm going to approach it is from the Catholic perspective because that's the one in which I am most familiar and it's the one in which I said I find the greatest richness in the history of it.

And the baseline theological reason as to why we argue that we have freedom and that we have conscience is because we are creatures of God and we are in the image of God. And of all places, we find this in the Inaugural Address of George Bush, in his second Inaugural Address, and he said the following. He said, "From the days of our founding, we've proclaimed that every man and every woman on this earth has rights and dignity, and this is because they bear the image of the Maker of heaven and earth."

So here you have a broad consensus at least that we have dignity, and if there's one thing that this commission has done, it's to write books on the dignity of the human being. And while there may be disputes as to what the source of this is, at least theologically it is because we are creatures of God. We are in the image of God, and God is at work in us.

Theology understands two things: One, we are to act on the basis of our conscience. We are to act on the basis of values. We are to act on the basis of what we perceive or understand to be right and to refrain from acting on what we understand to be wrong.

And theologians also understand that we can fail, that failure and error are part of the human condition. We can fall short of what it is that we want to do as the right thing. This is put best, I think, by St. Paul in Romans when he says, "The good that I would do, I do not, and the evil that I would avoid, I do." Why? Why do I not do what I resolve to do when I say, "This is the right thing to do"? And it's as easy as and as frequent as getting on that scale yesterday and discovering 160 pounds, which some people would think was great, but I think is terrible and say, "I'm not going to snack anymore between these meals," and on the way down to this talk, three carrot sticks and four dips later, what happened to the resolve?

Now, I don't think it's, as Paul would put it, sin, and I don't think it's really sloth or gluttony. But you say, there are things where we fall short. We don't do what it is that we want. But we do have values, and we identify ourselves by our values.

And I think we've seen that certainly in the story of John McCain when he's talking about his days in the prisoner-of-war camp, and he said, "Why did I do what I did? Because that is who I am." And he said, "I sat there thinking of my father and my grandfather and the values that I had and who it is. It would have been easy. It would have been in my self-interest to sign up to leave early. But that's not who I am."

Conscience has to do with character. And even a clear expression of that was seen in Tim Russert's

book on his father called *Big Russ*. His father was the superintendent of sanitation in Buffalo, and he was offered a big promotion if he would — offered a big bribe, rather — if he would allow somebody else to get the promotion on the list by taking himself off, and he said no. And when he was explaining it to Tim, he said, "Because that's not who I am. I define myself by my values and my conscience."

Conscience is an old notion. It goes back to the Hebrew notion of the heart, that the heart was the seat of reason, that the heart is the seat of our feeling. The heart is the seat of our decision-making. And the call of the prophets was to put on a new heart so that you would be faithful to the covenant.

St. Paul in Romans talks as well about the Greek and Hebrew notion of this fundamental awareness that's implanted in the heart of each of us, that's in our nature, that's ingrained, that all of us have somehow ingrained in our very being this sense of what is right and what is wrong, and that becomes the guide to our decision-making.

I think that the best single articulation of that in the modern world is one of the conciliar documents of Vatican II called *The Church in the Modern World* in which the Council fathers said the following, following along the same lines as the Hebrews, "Man has in his heart a law written by God. To obey is the very dignity of man for there he is alone with God whose voice echoes in his depths." And here they make the distinction between you find yourself alone in the depths of your very own soul — the words they would use using the Latin, *solo cum solo*, that is alone with another alone, alone with God, not as they put it, *solo cum se ipsa*, alone with oneself. That is, that God is implanted in our hearts, in our nature, in our being as a part of the dignity of being in his image, this sense, this capacity, for understanding good.

There are, I propose to you, three parts to this conscience. The first is the capacity for it, this natural capacity we have; then a process by which we discern; and then a judgment by which we make a decision to act.

Except for the brain-damaged, infants, and the psychopaths, it seems to me that everybody has an innate sense of right and wrong. They know what right is, and they know what wrong is. Thomas Aquinas called this that first kernel, that kernel of first principles that we all understand. And Thomas writes later, "Most people don't have the time, the capacity, or the inclination to do vast philosophical analysis." But we have, all of us, got this capacity to reason about what's right and what's wrong, about what the good thing to do and the bad.

Now it's important to understand that this foundation that we have is not the same as — and we don't have equal clarity or certainty — with applying this conscience to concrete situations in the human world. That's the role of the second factor of process.

Now that we have this sense, this innate sense, how do we begin to work at it? And it's through experience, through critical investigation, through looking to sources of moral wisdom. We know that don't ourselves have all this capacity, so we look to others, to family, and you certainly saw it in the political conventions. Every single one of the candidates began his or her biography with, "Here's my family. There's my 91-year-old mother. There's my 96-year-old mother. There was my father. I learned at my grandmother's knee." They went to their families. Then they went to their tradition, and then they went to the sense of their community. So you get this wisdom, not simply from your own self-reflection, but you get it from the wisdom of the community.

We get it in the broader perspective from the prophets, from scripture, from the tradition, from the Founding Fathers. We find this richness of the wisdom, and we go there.

And then, finally, you have a judgment. What is it that I ought to do in these particular circumstances, given my understanding of right and wrong, given the sort of history of where this all fits in? One of the ways in which this works — and I've talked to Dr. Pellegrino just two weeks ago wholly independent of this — we begin to apply this. There was in the August 14th issue of the *New England Journal of Medicine* a very controversial article about infant heart transplants.

And the proposal of the Denver transplant team was that we should, when removing a ventilator from a brain-damaged child, wait for death to occur, or wait for the cessation of cardiac activity, and then wait 75 more seconds to declare them dead and harvest the heart.

The commentary and the prospective in that same issue of the journal by a physician at Dartmouth says, "Wait a minute. What do you mean, 75 seconds? What about the dead-donor rule? What about auto-resuscitation? What about? What about? What about?" He said, "We have to look at the tradition of cardiology. It's not simply a matter of saying, 'We like hearts, and, therefore, 75 seconds is enough. Let's look to the tradition of medicine.'"

One of the judges, late judges, of our Supreme Court in Massachusetts, Paul Liacos in the Saikewicz case [*Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d 417 (1977)] raised the same sort of issue when the question came, could we remove or could we withhold chemotherapy from a patient, an elderly, mentally-incompetent patient with leukemia? And this was a case of first impression. The question had never been raised in the law before, and Justice Liacos says, "The law frequently lags behind technology." The technology has advanced. Now we have to have our moral reflection on it. And the law simply doesn't bring it out of thin air. As Justice Liacos puts it, "We look to philosophy and to theology and the tradition of medicine. We look to the wisdom of the society in order to determine what it is we believe the right thing to do is, law not being conscience, but law saying, "This becomes the reflection of the conscience of the society on how we behave in this particular activity."

That is, the formation of conscience is social in nature. It's not simply solipsistic. It's not simply, "I believe, and, therefore, it is." It's formed with experience and with knowledge and aware that we can have lapses. We look to families, to friends, to colleagues, and to experts in the field. We also look to stories, and to laws, to images, to traditions, to rituals, to norms. We look to all of these for insight and for understanding as to what constitutes the right thing.

Another factor is that conscience goes to character. It's not simply, "What should I do," but "What sort of a person ought I be?" John McCain put that so forcefully when he said, "This is who I am." This is how we act because this is who we are.

We also have to understand very clearly, of course, that conscience can err. Kerry Kennedy put this best, I think, in her new book [*Being Catholic Now: Prominent Americans Talk About Change in the Church and the Quest for Meaning* (Largo, Maryland: Crown Books, 2008)] — I haven't seen the book yet, but I heard it on NPR the other day — talking about how the nuns were talking to the various students in school and looked at one boy and says to him, "You have a superabundance of original sin." Now, I'd never heard that put that way before. I thought we all had it and all had it in abundance. But it's the only empirically verifiable theological concept we have, but it's there.

Knowing we can err, what then about conscience? Well, in the investigation, we might be mistaken. We might distort. We might have the wrong facts. We might be driven by passion. There is Plainville in *There Will Be Blood* driven by greed. It blinds him to all other aspects of life.

What about the erroneous conscience? What about the conscience that's mistaken either out of passion or out of ignorance or out of failure to do the homework? It can be what the theologians call, either vincible or invincible; that is, it can be conquered, or it's just intransigent. You cannot change it.

And Thomas puts it this way: "If by more diligent study you could have learned the facts, you have responsibility for changing." A simple example would be HIV/AIDS. When this first occurred, physicians didn't have an idea as to what this was and had lots of misdiagnoses. I recall a person whom I know now died of HIV, but this was before we understood what it was. And he went everywhere from Dana Farber to Stanford in search of a diagnosis. They said, "We can't figure out what's gone wrong." Were those doctors in error? Yes. Was it a moral judgment, a moral lapse? No.

Alternatively, if today a patient came to your hospital and had HIV and you said, "It sounds like the flu to me," this would be an error, but it would be a moral lapse as well. It would be the failure to exercise your knowledge.

Knowledge is going to include the ability to reason and to analyze. It also requires experience and reflection, not just information. It involves freedom, but not just to self-chosen goals. It's not a license to do whatever we want.

Another aspect is going to be the emotions. The emotions are a very important part of this, and that was what's missing in the psychopath. He has no empathy whatsoever. Those of you who have seen the film know that along the course of his way when he's going out killing everybody, he comes across the man in the store, and he says to him, "Flip a quarter." And the guy says, "What do you mean, 'Flip a quarter'?" He said, "Well, if it's heads, you live. If it's tails, you die" — no empathy about the human condition, no concern about anything, no regret, no remorse, just wanton killing.

Conscience is what the moral theologians call the proximate norm of personal morality. Now that will put you to sleep — if nothing else will today. What does it mean? It says it sets the boundaries for acting with integrity and for acting with a sincere heart.

What's the test of the validity of one's conscience? You say, "Oh, my conscience wouldn't allow me to

do that." What's the test? The test historically has been the willingness to pay the price of an adverse outcome for standing for what you believe in.

The best example historically, I think, is *Antigone*. You'll recall in Sophocles' play King Creon decrees that no one shall bury the bodies of those who are in revolt, and Antigone says, "My brother is my brother, and duty requires me to bury him." And she's advised, "Don't do this. You'll be killed." And she says, "I have a duty that transcends the law." That is the willingness to pay the price. In Martin Luther's, "Here I stand. I can do no other," the price was being excommunicated from the Church.

Thomas More in the Oath of Supremacy, his friend, the Duke of Norfolk, comes and says, "Oh, just come along and do it." And More looks at him, as you recall, and particularly in *A Man for All Seasons*, and says, "Oh, that's fine for you. Your conscience allows you to do that. And when you die, you go to heaven. And as for me, I go to hell." And Norfolk says, "Well, do it for friendship's sake." And he says, "When I go to hell, Norfolk, will you come with me for friendship's sake" — the test of your conscience, the test of your willingness to bear the price.

And in the long history of conscience, there've been disputes even against the Church. And amazingly enough, Thomas Aquinas in his commentary on the sentence of Peter Lombard says, "If your conscience tells you that this is wrong," Lombard says, "Your conscience can never go against the Church." And Aquinas says, "If your conscience — and you've diligently applied yourself to it — tells you that this is wrong, you should be willing to die excommunicated rather than violate your conscience," whereas Cardinal Newman said in a somewhat jocular vein one time, "If we were to toast a pope, I would toast first conscience and the pope afterwards because ultimately I am not going to be judged by the pope. I'm going to ultimately be judged by someone higher."

What do we do with the erroneous conscience? How do we deal with the erroneous conscience? If someone came to you and said — you go home tonight and you meet your spouse and he says to you, "Oh, dear. Some terrible news, but I want you to know he did it out of conscience," would you find those comforting or warning words? The fact that someone does it out of conscience doesn't necessarily mean it's right. The fact that someone did it out of conscience means, if it's a sincere conscience, that he or she believed it was right and was willing to do it, contrary to the norms of the standards of society, even contrary to the law, and willing to pay the price.

Aquinas picks up this question and he asks about the sincere conscience. He said, "There must be sincerity. There must be integrity in the individual in believing this, and the individual must also be striving to ascertain why it is that others are holding a different position. You owe it as an obligation to attempt to understand what the objections to your actions are, if there are them." If the person sincerely believes it and even if he's wrong, Thomas says, "Ah, this person is excused." He's not saying what he is doing is good, but he's excused from any moral impropriety.

Today, we'll find people very lightly using the theme, "It's my conscience." "My conscience wouldn't let me do that." And then you press further and you get, "My conscience wouldn't let me do that." And you press further, and you get the same answer. Well, what is there in your conscience that won't let you do it? It's not as Joseph Ratzinger called it, "It's simply the apotheosis of subjectivity. It's not simply, 'This the way I see it and that's the end of the story.'" He said, "In order to have your conscience be properly formed, you must know what the general rules are, the circumstances, the contingencies, to anticipate the consequences, and to anticipate what the response of the consequences is going to be."

An easy way into this is storytelling. Abstract theory, at least in my experience — and I suspect it's yours — when you stand there and give them abstract theory, they fall asleep. They want cases. And there's a big problem in medical ethics. They only want cases — no theory.

But let's look at two cases of conscience and see how conscience was formed. Did this individual know what was right and know what was wrong? Did he violate that without any impact on his conscience?

The first case I'd like to examine is David and Bathsheba. We know the story. David looks over and see the beautiful Bathsheba, lusts for her, does his thing. She announces she's pregnant, and there's a problem. She's got a husband who is a soldier in the army. So what does David do? He calls him back to see him, suggests he go visit his wife for the night so that he will have sex with her and think he's father. He said, "Oh, David, while my soldiers are in the field, I could not sleep in my own bed. I will camp on your doorstep." So the next day, David, continuing his cunning ways, invites him in for a big banquet and gets him drunk thinking this will dull his will — the same thing. Now David has got a problem. What does he do? He calls his generals in and said, "Bring this general out, put him in

front of the army, withdraw your troops, and he will be killed," and he was.

David thinks he solved his problems. David has no remorse, no regret. He's got Bathsheba. Where's his conscience? Does he have one? Is he a psychopath not knowing good and evil? The test is very shortly thereafter. The prophet comes to him and says, "Let me tell you the story of the man with one little new lamb and the rich man. The rich man takes the poor man's new lamb for his feast." And David looks and says, "As long as I am king and judge of Israel, that man deserves to die." He knew right from wrong. And the prophet looks and says, "Thou art the man," and David knew.

A more contemporary example of this is Chuck Colson. If you go back to the Committee to Re-Elect [the President] and you'll recall Chuck Colson's argument, "I would walk over my grandmother to achieve the reelection of Richard Nixon." It reminds me of [Thomas] More, but for Wales. Now he's in jail post-Watergate and reflects on it, and his comment was, "I lost my moral compass," much the same as Solzhenitsyn did in the *Gulag Archipelago* when he writes, "Here I was in prison, and I had these blue stripes on my tunic. That set me apart, and I did awful things." Now in prison — and not in prison for that, but in prison — he realizes how he had behaved, and he said, "I forgot the lessons I learned from my grandmother when kneeling at her side when she sat underneath the icon."

Colson, Solzhenitsyn, they had consciences. They had erred. They had failed. But they had not lost their capacity to reflect and needed simply the occasion, as did David, to reflect on the moral action and to be able to pronounce a judgment on it.

Conscience is not simply Jack Abramoff as he was last week saying, "Have mercy on me. I'm now the butt of jokes." That's not conscience. Conscience is what the theologians call that antecedent conscience. It's not the regret that you got caught. Conscience is before the action understanding and assessing its moral character and determining whether one should or should not do it because it is good or because it is evil.

Now the question — the question that Dr. Pellegrino and the question this group, this Council, is going to confront is — What about cooperating in what you understand to be wrong? Your conscience says it's wrong. When, if ever, may you cooperate, in what you perceive to be evil — what theologians call *cooperatio in male*? Must you refrain from all action that your conscience tells you is morally improper?

There are those who try to do that: H. Richard Niebuhr in *Christ and Culture* writes about Christ against culture. Culture is evil, rescind from it, withdraw from the evil world and keep yourself pure. The best articulation of that, I think, is J.D. Salinger's *The Catcher in the Rye*. Do you remember when Holden Caulfield is there with his little sister, Phoebe, and they go to that awful place called New York City and they see the terrible graffiti on the walls and Holden is going to erase the graffiti. But what does he learn? You can't erase all the evil in the world. You can't protect individuals from all evil, that in this world you're going to have to adjust somehow so that your conscience doesn't result in pure moral purity of the eschaton here.

Let me give you two cases broaching, bridging into where you're going to go, two legal cases. The law is not the definitive analysis of morality, but it gives you an insight into at least how we approach it. These are two recent cases of addressing exactly the issue: One, *Storman versus Selecky*, the 9th Circuit, 2000 [*Stormans Incorporated, et al. v. Selecky, et al.: U. S. District Court for Western District of Washington No. 07-cv-05374-RBL: "Order Granting Preliminary Injunction," November 8, 2007*], was the pharmacy case, and you're all familiar with this. Some states have laws insisting pharmacists do not have to violate their conscience. Some states say pharmacists must [fill all legally valid prescriptions]. We haven't sorted out that problem fully yet.

But the 9th Circuit looked at it and said, "If the pharmacist is being ordered to provide a contraceptive that he believes is killing the life of a newborn or of a newly-created life, he has no obligation to do it." The pharmacists wanted a refuse-and-refer, and the state wouldn't allow it. And the court said, "This is a Hobson's choice for this pharmacist. Either he violates his conscience or he loses his job," at least in the state of Washington, where this occurred.

A different case was one that occurred in California involving Catholic Charities, and it was the issue of insurance. If you have an insurance plan, the argument or the statute read, you must provide prescription contraceptives to all the insured. Catholic Charities protested and said, "This violates our institutional conscience. We don't believe that this is a moral action and, therefore, we won't." And the California court said, "It may well offend your conscience, but these people have a right to it," and the argument is very narrow. You would not have to provide it if you were an institution designed simply to inculcate religious values, if the majority of your employees and participants were members of this faith, and you were what the IRS calls a church; that is, a convent or a religious

order.

A convent of Carmelite nuns might have a legitimate argument as to why they would not provide insurance benefits involving contraceptive prescriptions, but does that apply to Georgetown University and Medical Center? Is this an institution designed to inculcate religious values? Are the majority of their people going to be of one religious faith? And is it specifically restricted to those? We'll recognize conscience in the narrow sense. But in the broader, it's not.

Those are just two ways in which the approach came, and it gets you into sort of one of the final descriptions of how it is: namely, what's the degree and intensity of the involvement of the individuals with conscience in the practice?

There's the question of — and we have it from 1973 from Senator Church's amendment on abortion. You need not — no physician or health care provider need directly be involved in the procuring of — I wouldn't even use *procuring* — in the *performance* of an abortion.

How far up does that extend? Does that extend to when Ed Pellegrino was a kid working in the pharmacy stocking the pharmacy with contraceptives?

The philosophers make the distinction between direct formal participation, which is a very high value, and then indirect and material.

Does the porter in the hospital who is pushing the patient down the hall to the operating room? Does the clerk in the insurance company who's processing the insurance claims have a right to say, "I believe this procedure is immoral. It violates my conscience, and I won't process the claim nor will I report the non-processing of the claim because others would be now involved in it."

Where along the line do you begin to draw the difference between direct formal participation in a grave evil and indirect material participation in an evil that the society doesn't quite find as egregious an act? And I think that MacIntyre put it best when he said, "If we're going to have a stable, social society, we must have some consensus as to what constitutes acceptable behavior or tolerable behavior, or otherwise we're in chaos." We simply have individuals saying, "My conscience is the only value and I am not willing to compromise in any way for any purpose," and then you have, not a society or a community. There you have chaos, and we'd be right back with Hobbes. And do we want to have a short, brief, vicious, and bitter community at each other's throats, or is there a possibility of saying there are some things that are so important, and so imperative, and of such value to an individual that as a society we would be willing to recognize that individual's right to rescind from direct form of participation in that form of behavior? But we've got to make distinctions as to where along the continuum that line falls. Thank you very much.

[Applause]

CHAIRMAN PELLEGRINO: Thank you very much, John. Gilbert Meilaender, Dr. Meilaender, will open the discussion. Gil?

PROF. MEILAENDER: Thank you very much for the presentation. I feel myself at a grave disadvantage on several counts here. A man who thinks that eating a few carrot sticks is falling off the wagon doesn't inhabit my world. I had six of those Burger King chocolate chip cookies at the airport yesterday. And a man who deals in these award-winning movies that I have not seen, I can't — if he were to comment on *Mamma Mia* or, dare I say, *House Bunny*, I've seen them and we could have sort of engaged each other on that.

Let me just raise a couple of points really to highlight some issues that come out, not to disagree, but just to note some things.

You began by saying that conscience is inner-directed, not other-directed, and, yet, if we think about the whole of your talk, I think that was too simple a formulation to capture what, in fact, you said. You later in talking about the process of discernment talked about the conscience as social, and, clearly, conscience is not in your view entirely inner-directed since one is alone, not with oneself but with God, so that an utterance of conscience is not simply self-assertion; thus, this is the person I am. It's able to be questioned so that in some sense, while there is that enormously important subjective aspect of conscience, there is also in your view an objective aspect in a way.

At least in respect to the relation with God and maybe somewhere else, when you first talked about the things we know about conscience, you said we that we can act on the basis and we know that we can fail, and you later used the word "lapse" — "We will lapse." But then you also asked the question, "Can we be wrong?" and your answer was, yes, so that there is some kind of objective aspect as well.

It's not just an assertion itself that's involved. And I think sorting out the relation between those two is what makes for some of the complications in the kinds of questions that we're facing.

When you said — and I don't know. I would defer to your judgment about what St. Thomas says, and I haven't looked lately — but when you said, what's the test for validity of one's conscience — and I think you were talking in the context of discussing Thomas, but I may not remember right — you said a willingness to pay the price for acting in accord with it. Now as I said, I don't know what Thomas said— but *validity* seemed like a strange word there, the fact that I'm willing to pay the price for it, at least in our normal use, if one grants it, there is an objective aspect of conscience. The fact that I'm willing to pay the price says something about my wholeheartedness but not necessarily about the validity of my conscientious judgment, I think, but I don't know. I'm just puzzling over that relation between the objective and the subjective.

And then, finally, just one more thing. When you came to the issue of cooperation at the end, which is really where we're headed, of course, you distinguished between formal cooperation which is, I think, really sort of embracing the evil as a good, which is always forbidden, and material cooperation in not-so-great evils, which, if the truth were to tell, we're all involved in all the time and you can't, as you said, live in society without that.

It leaves the category of material cooperation in a grave evil, and, of course, the difficulty of reaching agreement on what constitutes a grave evil, and that I wasn't so clear on either what you wanted to say or what any of us ought to want to say about it.

So just by way of a summary, I mean, I think that relation between the objective and the subjective, in various ways you came back to it, and sorting it out is really hard. And I think some kinds of cooperation are pretty easy to decide what we think about. But material cooperation in what one thinks to be a very serious evil is not so easy to work through.

FR. PARIS: Well, you found the difficulty I had in putting this talk together. And in talking with Dr. Pellegrino, he said, "I want you to talk informally. I don't want you to come and give a lecture."

And the relation between when talking about the super-ego and conscience in the early part saying the super-ego is simply other-directed, I was not implying that conscience has no other-directed as part of it, but it's trying to distinguish it from the super-ego which is exclusively other-directed. You simply incorporate the values of your parents and the authority figure and you don't want to lose their affection and, therefore, you do it, not because you believe that it's the right thing to do, but because you fear their disapproval. That's not conscience. Freud is on point on that with psychologists. That's something different because it doesn't have that sense, that innate sense, of "this is who I am and this is why I act the way that I do because these are the values that I have." It's just simply you don't want to incur the wrath of some authority figure. And I moved too quickly into that.

The same on St. Thomas. I moved in and out of St. Thomas several times. But St. Thomas doesn't talk about conscientious objection, that willingness to pay the price was moving over into, for example, the war issue, that you'd be willing to pay the price. You simply can't say, "I object to the war and, therefore, I'm not participating, and I am free." No, no, no, no.

There's a presumption that the laws are to be obeyed. There's a presumption that you are to fulfill your duties in society, and if your conscience says to you, "This is something evil," you simply don't proclaim, "I believe it's evil," and, therefore, don't participate. It's, "I believe it's evil, and I'm willing to bear the price," and the price for More is execution. The price for Luther is excommunication. The price for Ghandi is imprisonment.

And part of the price is, this will then affect the conscience of those who impose it and they'll see the injustice because of my willingness to accept it. This is very much what Ghandi was talking about, saying, "When they see the punishment that we will accept unjustly, then their consciences will be affected. They will be like David. Suddenly, the scales will fall from their eyes, and they will see."

And it may or may not be effective in implementation. But the argument that I was trying to make there was, the invocation of conscience alone doesn't absolve me from responsibility. And the test, the test which had nothing to do with Thomas, the test of the authenticity of my conscience is my willingness to suffer adverse consequences up to and including death for it.

PROF. MEILAENDER: I just note that you switched from validity to authenticity in that formulation. I think that's a better formula, the test of the authenticity would be. I'm not sure it's a test of the validity.

FR. PARIS: Oh, oh, you're right. You're right. You're absolutely right, yes.

And, oh, you didn't miss the point that I did not talk about, what your Council is going to have to discern, the tough and difficult parts. I just give the big picture. That's the role of the casuist. That's the role of the Council, because you are going to be casuists, taking the principles and applying to specific issues and trying to discern the prudent response to that in a community.

CHAIRMAN PELLEGRINO: Gil, had you completed your comment? Dr. Gómez-Lobo?

PROF. GÓMEZ-LOBO: I'm sorry. When I was listening to our speaker and to Gil, it suddenly felt a little bit strange. I said, "We are American public officials enjoying a theological feast at this moment. Should we be doing this or not? Where's the separation of church and state?"

And my little contribution to that question is this: Although our speaker said on several occasions "theologians say this," "theologians say that," and although if I'm well-informed, the bulk of Aquinas' theory of the conscience is in the *Prima Secundae* of the *Summa Theologica*, I would argue that it's not specifically a theological doctrine.

The fact that we're starting from principles known by themselves, *perse nota omnibus*, to everyone, not just *sapientarius*, not just to those who are wise nor *fidelirus*, not to those who have the faith, allow us to say, "Look. This is a theory about, partly about, moral psychology, about human understanding of action, and it's also a normative theory. But the whole of it, the whole of it, can be understood in purely philosophical terms."

That is the reason why this discussion is relevant to what we're going to be doing in the afternoon. In other words, it seems to me that the discussion this afternoon has to be to the effect that here we have an understanding of the particular judgment that a person makes about his or her action, such that society as a whole has to respect that or not respect that if we take the other position. But my inclination is to emphasize that, that the defense of conscience can be — not necessarily that it must be — but it can be defended on purely rational grounds.

FR. PARIS: You're absolutely right. That's how Thomas begins. The reason I use theologians — I mean, we end up quoting councils and popes, but they're reflecting now, not on received revelation. They're reflecting on rational analysis and philosophical discourse. But they were theologians, so I don't want to misconstrue that they were just — you know, they were philosophers independent of that.

But the fact is that within the Catholic Church this sort of discussion and debate has been going on for centuries and that's where the richness of the debate comes. But you're absolutely right. Thomas says everyone is capable of doing this.

CHAIRMAN PELLEGRINO: Dr. Elshtain?

PROF. ELSHTAIN: Well, thank you very much, Fr. Paris, for your interesting presentation. I'd like to get your reflections on a couple of statements that emerge in one of the documents in our briefing book, specifically the limits of conscientious refusal in reproductive medicine is the essay. You needn't have read it to respond.

FR. PARIS: I haven't.

PROF. ELSHTAIN: That's what I'm going to ask you. It's put out by the American College of Obstetricians and Gynecologists, the Women's Health Care Physicians Division. And there are a couple of interesting things here. One is that *conscience* is defined as private. And I took your argument to be that — and building on what Gil Meilaender has said — that that is not an adequate characterization of conscience, that there is an inevitable subjective dimension, but the reference point is always some notion of an objective moral law, and the presupposition is that human beings can be formed within that moral law and that that in a sense becomes the very substance or content of conscience that then is held, if you will, subjectively. So I'd like to get your comments on that.

And then one of the other claims in this essay we were given to read is that — and I'm sure you would agree with this — claims of conscience are not always genuine; that is, you can have, as you put it, an erroneous conscience. But that creates a terrific problem, does it not, when we're dealing with the kinds of issues that this Council is going to be talking about; namely, who makes a judgment as to whether a claim of conscience is or is not authentic or is or is not sincere? Do we have some body that adjudicates that? Do we make a case or make the argument that any claim of conscience has to be backed up by a set of stipulated reasons on the part of the conscientious objector before we acknowledge that claim of conscience as genuine? Or, again, alternatively to some other group,

simply claim — that's in a position of authority — or that can say, "We don't really think that's an authentic claim of conscience." So how does one sort out whether a particular claim of conscience is or is not a genuine one?

FR. PARIS: Well, to the first point on the privacy, I agree completely that that's a vast overstatement and misstatement. Conscience is not simply a subjective wish, whim, will, or desire. It's not that. It never historically has meant that, and I'm afraid that we've gone far, far, too far on this, what I call now, the autonomy run amok, that it's my belief and therefore -

PROF. ELSHTAIN: And that's it?

FR. PARIS: Therefore that's it, yes.

Then you come to the difficult question of, how do we assess, A, the sincerity of the conscience? Now part of that was in my answer to Prof. Meilaender, that historically what we've done — and the classic case was war, a conscientious objection to war — and then the willingness to pay the price, and it became a negotiated price within the society of willingness to be in the medical corps or willingness to — or go to jail or go to exile. But there were prices that were attached to it.

When you get into the medical side of it, a part of the issue becomes, in using the pharmacy bit as the early example, saying, "Well, if you find this offensive and we, as a community, insist upon this, then you may choose not to practice," and there the real test, I think, there becomes a legislative one, certainly not a judicial one. But the enactment of the law saying, if as a society, we believe that this violation forth sincerely held would be so appalling to the conscience of a civilized society or to an organized community, we will write exemptions into the law. You would petition for these, and they would be written, and that's how we organize ourselves in a democratic society.

I think you have to be careful though of there's a difference between a sincere conscience and then the erroneous conscience of saying, "Well, I don't do this because I believe that this is." An example of this — and I'm not going into details because I don't know anything about it — but is this morning-after pill, Plan B. And Dan Sulmasy wrote an article in the Kennedy journal on this saying, "Look. This is not abortifacient. You in conscience will not participate in an action that is abortifacient. But there's no physiological support for the argument that this is. So you have to do your homework better, and when you understand" — now whether Sulmasy's physiology is correct, I haven't a clue. But there's an argument where you can say, "This could be an erroneous conscience. You raise the question. And more work, more investigation, more analysis, more understanding of medicine..." — and it certainly persuaded the bishops of Connecticut and New York. They stopped their opposition on that on the basis of the argument that Sulmasy put forward and said, "Well, if it is true that this is not certain, then we cannot say it's a grave moral error when there's lack of certainty."

Who's right in this debate, I don't know. But that's an example where you could say, "Here's an erroneous conscience based on faulty facts." That's different from a sincere and factual, but non-supportable in the community.

PROF. ELSHTAIN: Can I do just a very quick followup? I was very happy you mentioned conscientious objection because, reading over some of these documents that called for more restriction perhaps on the operation of conscience, a conscience clause could certainly be used to limit conscientious objection in time of war as well. I mean, that would be one of the implications, it seems to me, that was not drawn by the folks writing this. Thank you.

CHAIRMAN PELLEGRINO: Dr. Carson?

DR. CARSON: Well, thank you for that very thoughtful discussion. And I certainly understand why you started out by talking about a theological basis of conscience because it's fairly easy to understand the concept of right and wrong if you have a theological base.

My question is, you said you certainly understood the point also -

FR. PARIS: The point that Alfonso made?

DR. CARSON: — the point that Alfonso made, about it being possible to have a well-developed conscience without a theological base. Now, let's say that man is the result of an evolutionary process that takes advantage of survival of the fittest. At what point in that process does the conscience arise? Should a lion have a conscience? Maybe they're a little lower on that scale when they kill a lamb or they kill the mother of a lamb and leave the lamb without a mother. I mean, where along that continuum, if, in fact, that is how things arose, does conscientiousness arise?

FR. PARIS: It arises with the ability to reason and to reflect upon one's action in a reasoned fashion and to formulate values and articulate those values as important for the assessment and understanding who you are. So it has to do with reason.

DR. CARSON: Well, if, in fact, it has to do with reason, why would it not be legitimate for someone to say, "My conscience tells me that I need to eradicate certain people because they're a scourge upon the earth"?

FR. PARIS: Well, we've certainly seen people who, at least philosophy — I wouldn't even use the word *conscience* — articulates that, and we, as a world community, hold them guilty of genocide or crimes against humanity.

PROF. ELSHTAIN: And those articulations, if I may just add this, are usually not made in the language of conscience. It's another rhetoric entirely that enters in when you want to exterminate categories of people. Usually a language of the will, a language of fit and unfit, a language that seeks to dehumanize those you aim to destroy, which in its own bizarre way, I suppose, could be a kind of underhanded tribute to conscience that says we don't treat fellow human beings this way, so you make them less-than-human. But I don't recall, for example, Hitler ever saying, "My conscience tells me to do this." It was a very different language.

CHAIRMAN PELLEGRINO: Rebecca?

PROF. DRESSER: Getting back to the analogy of objection to the military service, my memory is that draft boards did make distinctions about people claiming conscientious objections. So I was a little young for this, but I remember during the Vietnam War, some people said, "Well, the Vietnam War is immoral, but I can imagine a just war," and that wasn't being counted, that you had to be a complete pacifist.

I mention this because this has been suggested. I remember reading in an article about access to abortion and how many residents were unwilling to learn the technique and physicians unwilling to do it. And the question was, was this based on sincere conscience or a fear of protestors or the negative things that could come from that? And the suggestion was, well, we could have an examination of their beliefs to see how sincere they really are.

Now my view is, I don't think that would be a good thing to import into medicine, and I don't think it was very good in the military context either. But I wondered if you had any thoughts about that?

FR. PARIS: Well, actually, I wrote a doctoral dissertation on that subject. So you don't want to know all that I think about that.

What you had was a society, in fact, that, if we're going to make these kinds of distinctions and authorize some objection, you've got to have a bright line. You can't have a fuzzy line. And a philosophical objection to war in principle is a clear, bright line. If we're getting in a just war, which is the traditional Catholic argument and analysis, then you've got all sorts of areas in which there can be disputes and distinctions and there's no clarity on the behalf of those who have to judge, namely, the draft board, as to whether you sincerely hold this, whether you really hold this view or not. It's an impossible task, and we'd be right into wholly-subjective, self-serving withdrawal from it. So that won't work as policy.

It's easy to say it's all or nothing, and we understand and we're willing to accept and we're willing to accommodate those who are philosophically opposed to war in principle. But if I'm opposed to war because I think it's too costly on the American economy, that's not going to — how are we ever going to be able to calibrate that?

Over then into your issue with regard to residents declining to participate in this issue, you can say. Now, one of the very interesting phenomena would be if you had a whole class of people called physicians who all declined in this action. That might cause society to reflect and say, "What is it that they see that I'm missing?" And it's relatively easy to say, "Yes. I refuse to learn how to perform an abortion because I'm morally opposed. I believe it's a grave moral evil, and I won't participate in it." Now that might exclude me from ever being a gynecologist, but I'd be happy to be a dermatologist, radiologist, or ophthalmologist — better working hours.

But when you're setting policy, you have to have it in a practical way that you can discern which side of the line these people are on, and you cannot make a purely subjective assessment.

PROF. DRESSER: Yeah. I was just going to say that I think the bright-line rule is one thing, but the

sincerity is very difficult because how can we know?

FR. PARIS: It's impossible to test sincerity. Yeah, it's impossible.

PROF. DRESSER: And sometimes people are probably fooling themselves about what they believe. So as a policy matter, I think we can't say, "Well, it will depend on how authentic or sincere it really is."

FR. PARIS: That's too flexible a standard, I suspect, to be able to be judged objectively by an independent observer.

CHAIRMAN PELLEGRINO: Other comments, members of the Council? Dr. Hurlbut?

DR. HURLBUT: I'm only making a comment because nobody else is, okay, because I don't want to waste the — what do we have? Ten minutes left roughly with such a well-informed and thoughtful speaker?

I don't have this very well formulated, but I'd just like you to respond a little bit to the modern critique of moral theory that's emerging, often designated sociobiology or evolutionary psychology, and its erosion or corrosion at the core source of what we call moral conscience. In other words — and I'm sure you're familiar with this. Right? Am I right in that?

FR. PARIS: Some of it, yes.

DR. HURLBUT: So the comment is made that conscience doesn't necessarily have any transcendent referent of truth but is socially constructed. You've said yourself that there's a degree of communal grounding and conscience. Such thoughtful authors as Charles Taylor speak of the dialogical nature of conscience formation. In fact, I believe if you go back etymologically and look at the source of our word *conscience* and *conscientiousness* were joined together thinking together in moral matters, our very conscientiousness then itself is formed within social process.

The critics then say, "Well, these flow forward from a kind of functional utility that are to some extent relative to circumstances, to some extent whether relative to one circumstance or not at the foundation of biological adaptive advantage, in this case social engagement."

And what I'm trying to get at here — and I'll stop saying my part and let you say something — is basically the question comes down to in a modern society with so many diverse views of what medicine should be and what constitutes the good of medicine, this controversy obviously is about its most centrally — in medicine at least, it's most centrally oriented along the axis of the abortion debate. And yet for thousands of years, the moral traditions of medicine, the great weight, was against abortion. And yet people have new views on this and diverse views on this, likewise on many reproductive technologies.

It seems to me that what you're saying you're implying that there is something that overarches and transcends individual's thoughts of this and even social culture's constructions of it and that we must tap into that, when an individual is doing that, his claim to following conscience is legitimate; otherwise, it's not.

I guess what I'm getting at here is something maybe akin to a natural affirmation or something like that. Can you just carry that a little ways?

FR. PARIS: Well, part of it was the discussion I heard briefly this morning about what's the nature of medicine? Is this simply a business? Bud Relman wrote year after year in the *New England Journal* "At the peril of its soul, medicine will adapt the business model as its goal in its understanding."

And then we hear, "Well, I only treat patients who pay." It used to be that we would have patients and they didn't have the ability to pay, we treated them, there was no concern. Today, it's about contracts and capitated payments and covered lives and consumer-driven health insurance and, if you can't pay, well, too bad. And then you have others saying, "But that's not what I understand by medicine. As a profession, we have duties and obligations to sick people indifferent to their ability to pay."

I mean, the whole debate is how do we — which is how do understand ourselves? How do we understand who we are and, from that follows, how do we understand what we ought to do?

If you understand that we're just social constructs and that this is just simply a contractual relationship and my involvement in medicine is simply that, if you can contract for it and pay for it, I'll provide it, and those who haven't got the ability to pay, that's too bad. But then you say, is that

medicine? What's that got to do with the tradition of medicine? What's that got to do with how we understand ourselves as humans — which gets you right back into the question of conscience.

How do we understand who we are and what our obligations are? Are we simply just isolated monads in a world of Leibniz in which our relationships have nothing to do with anybody else? And, if so, I can be purely subjective. Or if, in fact, the impact of my actions have significant involvement with you, then I've got to be careful about what it is that I do so that I don't adversely injure you or hurt you.

It's a basic philosophical assessment as to who we understand ourselves to be as individuals and as a community.

CHAIRMAN PELLEGRINO: Thank you, John. If there are no more questions, we're five minutes before the termination of our session. I see none. Let us adjourn until — I'm sorry, Gil. Were you reaching for the microphone?

DR. HURLBUT: Well, while we're on it, why don't we really get to the crux here? You're basically affirming that there should be common terms of reasoned truth and conscience formation, that there is something that transcends individuals? It's not just opinion? I mean, isn't this the crux of our cultural dilemma here? We have the different competing concepts of the source and significance of world and our place in it?

I mean, is this resolvable? Are we just heading for two diverging theories of two diverging, what you might call, spiritual anthropologies, or do we have a foundation for finding a way to resolve these conflicts? If I understand it right, you're affirming there is the latter.

FR. PARIS: And it's a lifetime task. It's not solved in one conference or solved in one semester. It's a lifetime ongoing task, which I think is probably best seen by parents raising children. You can tell them. You can guide them. You can direct them. You can inform them. You can pray for them. You can work with them. But in the end, you can't force them. And when they err and fall, you don't abandon them. You bring them in and they are still — this is a loving, caring relationship. These are our children. This is what's precious. They've made a mistake, and we go back time and time again to try to do it.

So whatever it is, this discussion is not a philosophical debate that's resolved by analytical clarity. It's a lifetime commitment to trying to be what we were created to be.

CHAIRMAN PELLEGRINO: Thank you. Oh, no. Gil, I'm sorry. Were you going to speak? Forgive me. Did you want to respond?

I think, I mean, I agree with you that we need to have an answer. I think at least I have expatiated far too much in this in the literature, so I'm not going to say anything here at this point. But did you want to say something further?

I'll just end it by saying that there is an act of profession which you referred to when you become a physician, and the answer is, we do have an end and the immediate end is, as it always has been, the care of the suffering, the relief of pain and suffering, cure when possible, care always, and I don't think there's any argument about that.

The question is, how well do we do it? And I happen to agree with John that it is the task of a physician to reflect on who he or she is in relationship to the obligation one has professed oneself to at the very entry into the profession.

Now that's a little, again, a sermon, a sermonette. I'll be glad to talk a lot about it, but I think we're at this point and can maybe pick it up later on when we move to the more concrete questions of what the physician does when the patient wants X and the physician, both from the point of view of professional and moral integrity, thinks it is not to be done.

And I think we thank John for laying out for us some of the fundamental questions about conscience — that was the idea we had — and we'll move into the concrete questions and, therefore, John and Gil, I think we asymptotically at least approach your question.

Have a good lunch. We will reassemble at 2:00 o'clock.

SESSION 3: CONSCIENCE IN THE PRACTICE OF THE HEALTH PROFESSIONS

CHAIRMAN PELLEGRINO: Thank you. Thank you members of the Council. You're here on time, and we'll begin on time. This afternoon we turn our attention to the question of conscience in

the practice of the health professions, moving from the somewhat more conceptual and theoretical aspect to the actual difficulty and problem of conflict between conscience and the requirements of patients, society, et cetera, et cetera.

We're going to function as a modified panel, and I will introduce the members of the panel, and they will get an opportunity to speak in succession, and then following that members of the Council will participate in a discussion.

The members of the group are — beginning on my right, Dr. Farr Curlin , Assistant Professor of Medicine, Associate at the MacLean Center for Clinical Medical Ethics at the University of Chicago .

Next is Dr. Howard Brody , John P. McGovern Centennial Chair in Family Medicine and Director of the Institute for the Medical Humanities at the University of Texas Medical branch, and Dr. Anne Drapkin Lyerly , Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, and Chair of the Ethics Committee at the American College of Obstetrics and Gynecology. And Dr. Lyerly has asked us to point out that she is presenting on her own behalf and she is not representing the American College of Obstetrics and Gynecology or its ethics committee.

I think we'll immediately move into the program by asking Dr. Lyerly if she would kick off the panel.

DR. LYERLY: Well, thank you very much, Dr. Pellegrino , and thank you for inviting me to speak today. I'm absolutely honored to have the opportunity to speak to such a distinguished group and on such an important topic. I've been asked by Drs. Pellegrino and Davis to, in their words, map the contemporary domain regarding issues of conscience in the health professions. As Dr. Pellegrino noted, I should clarify that I'm speaking for myself.

In the last several years I've had the opportunity to think seriously about the question of conscience in the practice of medicine, both in my role as an obstetrician/gynecologist caring for patients, working with colleagues, training residents, and as someone who spends most of her time thinking about ethical issues in reproductive medicine.

I chaired and I currently chair the ethics committee of the American College of Obstetricians and Gynecologists, and I learned quite a bit about the topic of conscience during our deliberations. But as Dr. Pellegrino noted, the views I express today are my own.

Patients and their care providers do not always agree about health care decisions. Such differences are expected and usually, if uncomfortable or frustrating, are not morally — or not deeply morally — problematic. Yet occasionally a situation arises when a physician may find requested or indicated care to be morally objectionable and decline to provide such care on the basis of conscience. That is, of course, at the heart of our discussion today.

Such situations create challenges for professional ethics and social policy. What are the obligations of providers to their patients to provide information, referral, or care? To what degree should public policies be restrictive or protective of provider referrals, and what are the moral considerations that shape the answers to these questions?

So a quick overview. I'll begin with just a brief background, touch on current laws, policies, and the published views of professional organizations, again just to orient, since the question is how we ought to be managing issues of conscience going forward. I'll then turn to the contemporary ethical debate and highlight just a few themes that have emerged with some consensus as relevant to determining how restrictive or protective we should be of conscientious refusals. Finally, I'll end by looking squarely — or at least naming — some of the fundamental distinctions that may be helpful in framing a discussion.

Another disclaimer: I'm not a legal scholar, so I'm just going to stick to the basics here. Since the early 1970s laws have accumulated that are protective of providers' rights of conscience. Operative federal regulations include the Church Amendment, the Coats Amendment, and the Weldon Amendment. The force of these regulations is to protect individuals, institutions' training programs, insurance companies, and others from requirements to participate, or discrimination for not participating, in abortion and sterilization.

As noted in your briefing book, state laws also protect practitioners and institutions from participating not only in abortion and sterilization, but in the provision of contraception, and in some cases protections have extended to any health care task that is against a provider's conscience.

In response to concerns about access to needed reproductive services, a number of state laws have been passed which press in the other direction which are suggestive of a need to limit refusals in the

interests of patient well-being. Twenty-seven states have passed contraceptive equity laws which require insurers who cover prescription drugs to offer a full range of contraceptives approved by the FDA.

Sixteen states have passed emergency contraceptive laws, such as the "Compassionate Care for Rape Victims" law, which requires that emergency departments provide information about emergency contraception to special assault victims, dispense EC on demand, or both.

Finally, a handful of states and pharmacy boards have passed laws or policies that say pharmacies must fulfill all valid prescriptions. And so you see the tension reflected in the state and federal laws on the one hand pressing for the protection of providers' conscientious refusals and on the other hand protecting the rights of access for patients.

I think it is important at the outset to note that while the bulk of these conversations have taken as their central concern the provision of elective abortion or abortion on demand, as some call it, there are a breadth of services that some consider morally objectionable. These range from the provision of oral contraception to blood transfusion to the provision of vaccines whose development depended on the use of fetal tissue.

Most of the examples I use today will be situated in the realm of reproductive medicine, but it is important to remember the breadth when we look toward policy, and as we do, to be careful that our policies about conscience in general are not dominated by the question of restrictions on abortion.

While the ACOG document on conscience has garnered considerable attention in the last several months... issues of conscience have been addressed by a number of both national and international professional organizations. And I've listed just a few of them here. I'll concentrate on statements from the AMA's Council on Ethical and Judicial Affairs, the UK's General Medical Council, and the International Federation of Gynecology and Obstetrics or FIGO.

Most of these documents begin, or at least at some point in the document there is a statement about the primacy of patient welfare. You must make the care of your patient your first concern. The primary commitment of obstetrician/gynecologists is to serve women's reproductive health and well-being. A physician while caring for a patient must regard responsibility to the patient as paramount.

The second thing is that most of these organizations have advocated finding a middle ground, a middle ground between categorical views on either side, either that there's an absolute right to the expression of conscience or there's no right to object. These organizations suggest instead that rights to object should be protected but limited.

The AMA put it this way: "Physician's conscientious objection must be counterbalanced with obligations that will respect patients' autonomy and ability to access medical services." The UK General Medical Council says that their guidelines were meant to balance doctors' and patients' rights, including the right to freedom of thought, conscience, and religion and entitlement to care and the treatments to meet clinical needs and advise us on what to do when these rights conflict.

In striking the balance, professional organizations tend to comment on three areas of particular controversy with respect to individual providers: obligations of providers to give information about treatment options, obligations to refer patients to another physician if the service cannot be provided in good conscience, and obligations to provide the service itself when referral is not possible or practicable in emergency situations.

Of course, all of these issues raise the important concerns that Father Paris raised this morning about cooperation. So let's take a closer look. The General Medical Council with regard to information says, "Patients have a right to information about their condition and the options available to them. You must not withhold information about the existence of a procedure or a treatment because carrying it out or giving advice about it conflicts with your religious or moral beliefs."

The AMA says, "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives." FIGO says that "Practitioners have duties to inform their patients of all medically indicated options for their care, including options in which the practitioners decline to participate."

A referral is also addressed by most of these organizations. Again, referral has been an even more contentious matter than the provision of information as it brings up the concerns of cooperation and moral complicity. The AMA says, "A physician who refuses to provide a treatment still owes an ethical responsibility toward the patient. In most circumstances physicians who refuse to provide

treatments on the basis of religious or moral objections should refer patients to other physicians or health care facility."

Referral actually brings up practical questions among practitioners about what exactly is meant by referral. Must you identify a specific physician? How sure must you be that that provider in question provides the service in question? The UK developed a description that captures a spirit that some have found helpful. "You must tell patients of their right to see another doctor with whom they can discuss their situation and ensure that they have sufficient information to exercise that right. In deciding whether the patient has sufficient information, you must explore with the patient what information they might already have or need. If the patient cannot readily make their own arrangements to see another doctor, you must ensure that arrangements are made without delay for another doctor to take over their care."

And, finally, while almost all organizations affirm that providers are justified in refusing to participate in procedures that they find objectionable on moral grounds, they uphold the obligation to provide care in emergency situations. Patients are entitled to be referred — well, this is another referral one, but it essentially says the same thing.

So provision of care. "In emergency situations to preserve life or physical or mental health practitioners must provide medically indicated care of their patient's choice regardless of the practitioner's moral objections."

Similarly the American Academy of Physician Assistants says something along those lines: "Physician's assistants are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them."

So what are some of the ethical considerations that have emerged with some consensus as salient to moral deliberation and policy making around conscientious refusals? Many conversations will begin with the importance of conscience in the profession, the idea that it is critical to good medicine and bioethics that physicians exercise independent judgment, that they should not forsake moral integrity when they enter the practice of medicine, and that conscience is critical to democracy, bioethics, humanity. I suspect that we will hear — we've heard some on this already, and I suspect that we'll hear more from the other panelists with regard to this.

When we hear these arguments, it's easy at first blush to say no when asked about whether a physician should ever act in opposition to her conscience. But I'm going to take a few minutes to discuss a sampling of moral considerations that press against the starker, simpler way of thinking about these topics.

Many of these considerations focus, as I have focused in my career, on the patient who is often in the position of vulnerability in the context of the asymmetrical patient/physician relationship as a need that must be met and who is unable to walk away from the situation.

So what considerations are relevant to her? Three areas tend to emerge. The first are questions of health or welfare and the harms that might derive from non-provision of information, referral, or care. Second are questions of fairness, and third are questions of respect. So I'm going to take these one at a time.

Let's talk about health. Consider a case in 2000 known as *Shelton versus the University of Medicine and Dentistry* [*Shelton v. University of Medicine & Dentistry*, 223 F.3d 220, 224 (3d Cir. 2000)]. This was in the year 2000. In this case a woman presented to a New Jersey hospital 18 weeks pregnant with a condition known as placental previa. She was bleeding significantly. She had had a couple of other episodes of bleeding in the previous days, and this was a significant hemorrhage.

Now, you have to understand that placental hemorrhage associated with previa is not like bleeding from a cut on your arm or even on your head. As some of you who may have had children know, those can be significant, but it's more than that. In fact, the volume of blood that can be lost in minutes is tremendous, like a garden hose turned on full blast.

The attending physician called for an emergency C-section, but the nurse on duty declined to scrub in since the surgery would result in fetal death due to the delivery prior to viability. The surgery was delayed for 30 minutes. Fortunately in this case that was not too long. The patient was able to be supported while another nurse was identified to take the objecting nurse's place, but it may just as easily have gone the other way. So there was the potential for harm associated with refusal, even mortal harm.

The expression of conscience here kept the life and health of a pregnant woman in harm's way. This

case is famous actually — or known — for the fact that this nurse was offered a position elsewhere in the hospital but declined and was eventually fired and sued the hospital for discrimination, but she lost because the hospital had tried to accommodate her.

In other cases the welfare setbacks may be less obvious, but they are there. The woman who requests sterilization at the time of Caesarian section, for example, when her abdomen is open, her fallopian tubes are in reach, a couple of minutes and the operation is over, but due to her physician's objections to the sterilization procedure she's required to undergo a second operation weeks later and take on the risks of anesthesia and entry into her abdomen. So the patient incurs risk, and there's potentially harm to herself due to these objections.

Other harms can be described. I myself have accompanied a patient who, following a rape, was declined access to EC in an emergency room. I witnessed the harm associated with a traumatic decision she had to face between pregnancy termination and gestation, birth, and parenthood of a child conceived as a result of a profound bodily violation.

The second are concerns about fairness. How do we think about conscientious refusals when they differently affect different groups? Dr. Paris noted that he hesitated about mentioning the case of Guadalupe Benitez, but I will mention it, a woman who was denied intrauterine insemination for the treatment of infertility.

And while the terms of refusal have been a point of contention, the refusal seems to have been based on the provider's objection to fertility treatment for lesbians. In broader brush strokes, many have highlighted the fact that conscientious refusals to dispense contraception may place a disproportionate burden on disenfranchised women, reinforcing an unfair distribution of benefits and burdens. And while the scope of conscientious refusal, of course, stretches beyond areas of reproductive medicine, when reproductive issues are at stake, women are disproportionately affected.

Third and perhaps most importantly are questions about respect. Some will call this respect for autonomy, about how refusals affect women's bodily and others' bodily dominion. In many ways this brings up the stark question of choice and the divisive topic of abortion on demand, but let me bring up a subtler case.

As many of you know, for some women pregnancy is life-threatening. For women with pulmonary hypertension, for instance, mortality associated with pregnancy can approach 50 percent. Consider the case of a young woman with just such a cardiopulmonary condition. Imagine her pregnancy is desired. Imagine that politically she is pro-life, perhaps conscientiously she's pro-life, and her provider shares her view. So despite the morbidity associated with her anticipated gestation, the topic of abortion is not raised, she's not counseled about termination of a pregnancy that may threaten her life.

The fact of the matter is that pregnancy in the setting of a life-threatening medical condition is a difficult situation and a situation that entails the critical human question, what am I willing to die for? By not raising the question of abortion, the provider fails to respect in a very deep way the patient's right to consider that question for herself.

Another set of considerations derives specifically from the fact that we're talking about the practice of medicine, which carries role-specific responsibilities, and these considerations actually press in both directions. As legal scholar Alta Charo has famously noted, an absolute right to refusal cannot be supported since medicine has duties that derive from its status as a monopoly.

She states, "States give these professionals the exclusive right to offer such services. By granting a monopoly, states turn the profession into a kind of public utility obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust."

Others have argued that individuals enter the practice of medicine cognizant of the fiduciary duties it entails. Again, provocatively, Savulescu noted in the *British Medical Journal*, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."

In the other direction, proponents of conscience protections look to the nature of the medicine itself as a healing profession in justifying refusals to perform services they see as non-beneficial, harmful, or deeply, morally wrong. And then, of course, there's the question of scientific integrity, and this speaks both to the question of the validity of the claim based on the idea that the practice of medicine should be evidence-based and that refusals based on inaccurate or incomplete

understanding of science should be questioned.

Of particular concern have been claims about the mechanism of action of emergency contraception. Despite a broad misconception that this medication works to prevent implantation, the literature indicates that it prevents fertilization, like other forms of oral contraception. A review in the *Journal of the American Medical Association* in 2006 indicated that the ability of Plan B to interfere with implantation remains speculative since virtually no evidence supports that mechanism and some evidence contradicts it. The best available evidence indicates that Plan B's ability to prevent pregnancy can be fully accounted for by mechanisms that do not involve interference with post-fertilization events. The authors of this article advocated at the very least women should be apprised of such. This can obviously play out in other arenas — refusal to withdraw nutrition and hydration based on the view that it's cruel to starve a person a death, et cetera.

So moving forward, how might we think about these considerations? How should we think about balancing patients' needs and providers' critical interests in maintaining their personal integrity? Public policy is at best a blunt instrument. What it can't be is subtle and expansive enough to be responsive to the breadth of provider convictions or the nature of meaning and the consequence for the patient.

What it can do is provide rough guidance that sets a presumption about how we should reason. There is an ongoing debate about what that presumption should be. There are those that advocate that the rights of conscience should prevail in all cases, but there is a strong case for an approach that balances the immediate needs of patients with the interests of doctors. The question is how to balance.

Some considerations in terms of balancing might be fairly straightforward. So we know in situations outside of medicine that the validity or authenticity of a claim can determine whether we allow conscientious refusals to guide decision-making. In medicine those things might also be important considerations. Professor Dresser has written eloquently about the ways that distaste for certain procedures or discriminatory factors may be masked by claims of conscience.

But then there are harder questions. It seems to me that there may be a qualitative difference in the way that we balance claims of conscience with patients' interests depending on what is at stake, depending on whether the question is one of welfare, differential access, and, perhaps the most challenging, questions about bodily dominion.

The economies of how we balance may be different depending on what is at stake. If we want to talk about the conditions that must be met to conscientiously refuse to inform, refer, or provide care, how we balance may be different depending on what morally is at stake.

Moving forward, just a few things to consider. At the level of the individual provider, ongoing debate centers around obligations — how should we think specifically about the responsibilities of prior notice, the provision of information and referral.

Of considerable interest — and Dr. Curlin and I spoke about this over lunch — is the role that conversations might have in the process. Might there be a role for respectful conversations involving disclosure of a physician's moral views? Could that soften the sense of complicity?

At the level of institutions some have considered establishment of systems to provide information and referral and staffing that maximizes protection of patient interests and providers' rights of conscience.

Finally, some have advocated shared responsibilities so that the responsibility to uphold the interests of patients does not lie with the individual provider, but it's shared with the institution in which that provider works. But it is in part a responsibility of the individual.

In Portugal, for example, physicians are required to register refusals and then are prohibited from counseling patients seeking elective abortion. The law there states that the health system is obligated to ensure that patients receive care within a time frame responsive to patients' needs.

In the end the question of conscience presents important challenges for professional ethics and public policy. As the Council moves forward, I encourage you to do so acknowledging the nuance of balancing and with an eye not just on the integrity of health professionals but on the asymmetry of the patient/physician relationship and the vulnerability and fragility of patients who request our help.

Thank you very much.

CHAIRMAN PELLEGRINO: Thank you very much. Our next speaker is Dr. Howard Brody .

DR. BRODY: I would like to echo Dr. Lyerly 's comments of gratitude for the opportunity to speak with you this afternoon and be part of this very important process. Dr. Pellegrino has already scolded me with regard to the quantity of slides that I brought with me, so I promised that I would move expeditiously. And I've also, at least by e-mail attachment, made available to the Council a manuscript, which is a somewhat fuller elaboration of what I have in the slides, and if any of you are seriously bothered with insomnia, I trust that you'll be able to get copies of that for your perusal.

What I wish to do with you this afternoon is to start with a very brief case study to simply give us a concrete example of what we're talking about, and then I want to spend most of my time offering an account of how to think about conscience and why its dictates may differ from professional obligations and basically present to you what I'll call a two-promises model. And then I will try to suggest at the end, perhaps rather briefly, that there are helpful ways that this two-promises model gives us suggestions that may possibly help in resolving conflicts.

So the case study I'm going to focus on is the case that appeared initially in the American Journal of Bioethics that a colleague and I responded to in a paper that I suspect may have had something to do with my having been invited to speak to you. And basically this is a situation of the prescription of the morning-after pill or emergency contraception where the prescription is presented to a pharmacist, and the pharmacist objects to filling the prescription based on religious or philosophical grounds, perhaps any use of this medication or perhaps for this particular patient.

And the key assumptions here are that the pharmacist here is a health professional so that in important ways is analogous to a physician or nurse or other health professionals, and the debate we're having — although we need to talk about this some more — is not primarily a scientific one. It's not that the pharmacist says the risks are much greater than what the physician thinks or that the efficacy is much less than what the physician thinks who wrote the prescription.

And I was not aware at the time that I started working on this the extent to which apparently you wish to talk about end-of-life issues as part of this general session, but I would suggest that this case is in important ways analogous to end-of-life issues as well, because if you think about end-of-life issues, either to provide aggressive life-sustaining treatment or to provide palliative comfort oriented treatment that's providing a sort of package of care to the patients, then, again, you have the situation where the provider is being asked to provide a treatment of some sort to the patient and the provider has a conscientious objection to offering that package of care. So I think we can use this case as a jumping-off point for the more general discussion.

So I want to talk about how we should construe a conscientious objection, and all through I'm going to assume a good-faith, honest appeal to conscience, not an insincere appeal to conscience. What is the relationship between a conscientious objection and acting with professional integrity, and do the requirements of personal and professional integrity differ?

So I think it's a little easier, actually, to start with professional integrity, and I'll start with citing the work of Dr. Pellegrino here in which he highlights the notion in some of his seminal papers on this the act of profession or the verb "to profess" as being critical in understanding professional integrity.

And I'm going to argue that to profess is to promise, and it has two elements that are very important. It's a public promise, and it's a collective promise. So the medical profession — in my case, we all stand up together when we graduate and we all say the oath and we all say it publicly. So the fact that we all do it together and we become a part of a medical collective via the saying of the oath and that we do it in public and the public is supposed to hold us accountable are both important elements of what it means to act with professional integrity.

There's a lot of different accounts as to exactly what we promise, what is the content of the promise, but virtually every account that I know of in one way or other says that we elevate the patients' interests in some way, shape, or form above our own personal interests.

Now, the question that might be asked is, does one own interest include one's personal integrity? Now, the first answer to that question is, well, it can't possibly because my personal integrity is my deepest moral possession, if you will. So how could I give that up in the name of professional integrity?

But I would remind you that that may be — we could raise at least a prima facie question about that because many of us believe — I certainly believe — that one of the things that we promise when we make this collective, public promise is — as my infectious disease friends tell me when the H5N1

virus mutates and we have a flu pandemic of an avian flu variant that's transmissible person to person — that I have made a promise as a physician to potentially risk my life to serve the patient.

So it could be asked, are you saying that health professionals made a promise that they're willing to risk their lives but that they're not willing to risk their personal moral views? So at least that question can be raised. It doesn't answer the question, but I think it legitimizes raising the question.

So now let's turn to personal integrity, and I'm going to use conscience and personal integrity largely as synonymous terms. Now, a very popular account of this is that conscience is an inner moral sense which is attuned to an external source of moral truth, such as divine law. And this has been very popular, and I believe if you did a public opinion poll it would get a lot of assents, but my colleague, Martin Benjamin, I believe very thoughtfully in the analysis of conscience that he did for the Encyclopedia of Bioethics showed that there are serious concerns with this popular account.

First of all, some of us, at least on occasion, experience conflicts of conscience internally. Our conscience seems to be telling us two different things at the same time. And this account of conscience could not possibly account for that.

And then there's a question ultimately of whether this creates a viciously circular argument. Is our conscience right because the external source is true? Do we know the external source is true because our conscience is always right? And what comes first? So there are some serious conceptual problems with this particular view of conscience.

So another account, then, says, well, let's forget about the external source of moral truth and let's say that conscience is an internal standard. And I think that's an appealing account in one very important sense, that if you've honestly and earnestly consulted your own conscience, I don't think we can imagine an effective appeals process.

It's incoherent at a certain level to say even though your conscience tells you that you must do X, I'm telling you that you really ought to do Y instead. It's very important to see that that assumes a level of appeal which I think the whole concept of conscience disagrees that that level of appeal exists. But a strictly internal account may fail to capture important developmental and social features of conscience. And I didn't have the opportunity to be here this morning for Father Paris, but I believe that he may have alluded a little bit to that idea.

So I'm going to play philosopher here for a minute and go on a little tangent, because I think there's an interesting idea that we can bring back into the idea of conscience from John Rawls' Theory of Justice.

Now, John Rawls' Theory of Justice says that one of the most important primary goods is this thing called self-respect. And what does it mean to respect yourself? It's very, very important if you're going to have a life worth living that you respect yourself, says Rawls, and a critical element, as he gives an account of this, is having one's plan of life approved of, affirmed, by a special group of people.

And he doesn't give a name to this group, so the only thing I can come up is this unpronounceable acronym of the Rawlsian Life Plan Review Group. Well, who are these people? Okay, so these are people you respect. You get self-respect because people you respect respect you back again. These are people who you think have special insights into who you are uniquely and what would be a rational life plan for you, and these are people whom you freely choose to occupy this role.

So we can imagine your parents, if you agree with the basic values of your parents; special mentors that you had when you were growing up; and perhaps some close friends are candidates for this life plan review group. So the idea is, if this group of people affirms what you're making of your life and show that they respect you because this is what you're doing with your life, you are then entitled to have self-respect, and this sense of self-respect is a very important good.

So I want to then say, can we play with this a bit. And in order to play with this, I want to go off into an area that some would call a narrative approach to ethics, but I think when people are asked to give a narrative account to justify a moral choice, one thing that crops up in discussion commonly is this idea of keeping faith. And it is sometimes expressed as "my grandmother would turn over in her grave if I did that" or something along those lines.

And what I'm going to suggest is the people who we feel a moral need to keep faith with when we give this kind of justification for why we did something that seems very deeply rooted in our core identity as a moral individual suggests that those same kind of people who would be on the life plan review group in the account given by Rawls might be the candidates to be the ones with whom we have to

keep faith in order to be people with integrity.

The speculation I want to now bring to fruition with this is that the idea that keeping faith in this sense seems to resemble an act of promise keeping. It's as if I promised my grandmother or my mother or my father or my favorite teacher when I was in grade school that I would never behave that way, and I need now today to keep my promise. And my motive today, to be sure that I do this behavior, is the felt need to keep my promise to these very important figures that had this formative role in making me the person today that I am as a moral being.

Now, this is not a good reason from a philosophical point of view, but I think sort of indirectly supporting this is that it gives some credence to popular culture depictions of conscience. The Jiminy Cricket idea, the voice in one's ear, the miniature person sitting on one's shoulder that I used to see in the Saturday morning cartoon shows suggest the idea of this person or this group of people to whom I have made prior in my life this important promise and now they're holding me to live up to that promise.

So basically what I'm suggesting here, to try to pull these threads together, is that conscience is what my internalized group of special moral mentors or guides from my early moral development tell me that I ought to do as if I have promised them to behave in that way, again emphasizing they're certainly not here now. I don't pick up the phone to call them. They may, in fact, not even be alive anymore.

Now, does this mean that conscience is nothing but an internalized set of social norms from early child development? And Benjamin again says that would be a totally flawed and insufficient account. You could never defend a serious moral weight being placed on the dictates of conscience if it was nothing other than "Well, that was the way I was raised." So if I was raised in a terribly bigoted and prejudiced society and that somehow justifies my being a bigoted and prejudiced person. Absolutely not.

So it's important, I think, then, to see what's going on here, that this Rawlsian narrative account of conscience's promise is different from merely invoking social norms. It presumes a conscious and reflective act of choosing certain individuals to be part of one's life plan review group or promise-to-mentor group. And so, for example, it's interesting when people exclude their parents, when people say, "My father was a bigot, and he brought me up to be a bigot, and I'm not going to be a bigot. So I will not allow my father to play this role in mentoring me for my moral behavior as an adult. I reject my father's candidacy for membership in this mentor group, and I didn't promise my father that I would be like him, and I won't," so that there's a reflective processing of this input. It's not a blind acceptance of the social environment in which one was brought up.

So I'm suggesting in summary that personal integrity or conscience represents a private promise to behave in certain ways to this special group of people who I feel I owe this role in my life to who helped guide me to become the person that I am. Professional integrity grounded in the act of the profession represents a public collective promise to act in certain ways, specifically to be faithful to the interests of the patients, and therefore it would not be a surprise if the content of the two promises conflicted with each other. So we have two promises which could easily come into conflict, and there we have the so-called conflicts of conscience in the clinician.

Now, how do you resolve this? Well, the first important thing that follows from this account is, you do not resolve this by denying the moral weight of either personal integrity or professionalism. Each is an important way to a considerable extent to the good professional identity constituting. Certainly my personal integrity is identity constituting. Who I have selected to be my special moral mentors and I feel obliged to act as if I promised them to keep faith with them — I would behave in those ways— that is at the very core of my moral identify.

And one of the things it means to say that I'm a professional and that medicine is not a mere occupation, for example, is that that becomes a part of one's identify, and my moral commitment to my field, my service commitment to my patient, is part of who I am. So both of these are to some extent, at least, identity constituting promises. Neither can be taken lightly. Neither can be simply dispensed with.

Now, the rational conversation idea, the counseling idea that Dr. Lyerly alluded to, highlights something that is complicated about the idea of conscience. It may be that there is no higher court of appeal than my own conscience. That does not mean my conscience cannot be mistaken. Conscience is corrigible. So how can conscience be mistaken? I think it's very important that we list these ways.

First of all, as was already pointed out, you could have the incorrect facts. You could not know how

certain drugs work, at least in the minds of certain investigators who have elucidated the mechanism. You could certainly adhere to moral principles or rules at one time in your life so that at that time in your life that rule is the highest moral court of appeal, but at a later time in your life on reinvestigating those moral rules you could find they were flawed and you could come to what you hope is a higher level of understanding of morality such that you no longer adhere in the same way or to the same extent to those moral principles that guided you.

And then I think there's an under-appreciated way the conscience can be mistaken, and that's what I would call single-issue conscience like single-issue voting. That is when you allow one dictate of conscience to assume such prominence in your thinking that you ignore other dictates of conscience. And I'll come back with some examples.

Now, an important distinction that I think guides us into how easy or how hard it's going to be to resolve conflicts of conscience in practical health care settings is — I'll offer a distinction between a mild and a strong interpretation of the dictates of conscience. A mild interpretation of the dictates of conscience essentially requires that one stand aside: "I should not participate in this procedure or this treatment that I morally object to."

A strong interpretation of the dictates of conscience requires acts that start to amount or actually amount to interfering with the patient's access to those services. So refusal to refer is a common one, and I have heard at least anecdotally of one instance where not only did the pharmacist not fill the prescription, but the pharmacist confiscated the prescription, would not give it back to the patient, so the patient was prevented from going to another pharmacy even if there was one just up the road where they could have gotten the prescription.

So those are strong interpretations of what conscience requires of you. And there is where I think that we start to see what I mean by the single-issue conscience, because let us take for a minute the pharmacist who basically stole the prescription from the patient. That pharmacist would say, "Well, my conscience told me I had to do this," but did this pharmacist promise his mother and his grandmother in those moral guides that he grew up with that he would become a thief? Probably not.

So this pharmacist, I would argue, was allowing one moral commitment, which is a part of his conscience, to cause him to forget that he had made other moral commitments also in his conscience, that none of our consciences, if we're like most people, are single-issue voters. And if we want to follow the dictates of conscience, we are duty bound to buy the whole package. We have to remember what other commitments of conscience we may have and not allow one single one which is particularly in focus at one particular moment in time to cause us to lose sight of the other dictates of conscience.

So the kind of balancing act I think we're struggling with here in many cases is the more that the strong interpretation is favored over the mild interpretation, the more difficult it's going to be to reconcile the individual professional's objection with basic duties owed to the patient. And this is going to lead to cases like the one — the court case that Dr. Lyerly mentioned, where we're going to have to say in some cases that a professional with such stringent dictates of conscience ought not choose that particular career, that they cannot at the same time promise they're going to serve the interests of the patients if their individual personal integrity requires them to say no to so many things that could possibly be a part of the needs of the patient.

An extreme case that I was made aware — and I'll talk a little bit more about that hearing later — in the State of Michigan a state senator, who also happened to be a physician, remembered when he was in residency at the University of Michigan that one of the anesthesiology residents was a Jehovah's Witness and would not give a blood transfusion to a patient who was bleeding out in surgery. And eventually they had to fire this resident.

So you could argue that you could be a Jehovah's Witness, but you can't be a Jehovah's Witness and be an anesthesiologist. You've got to choose at some point if it's that important a commitment for you.

Now, fortunately most of the time it's nowhere near as bad as the case of the Jehovah's Witness anesthesiologist, and the more that a mild interpretation prevails, the easier it seems to relocate responsibility for handling conflicts at the system's level where we can replace the professional temporarily who has objections with one who is willing to provide the services and that these conflicts can be anticipated and allowed for as you look at the scheduling issues and the way that you staff and deal with your personnel in your particular pharmacy or your hospital or your L&D unit or wherever you may be the manager of.

Obviously this is going to have problems in particular instances. It's particularly going to be a problem in a rural health setting where there may not be that many alternatives available, where the other facility may be many miles away. This may, in turn, argue for limits on where a professional with stringent dictates of conscience may elect to work. Alternatively, it may require a greater personal willingness to participate in arranging referrals and other alternatives if the person with the strong dictates of conscience does elect to work in a more rural setting where they are the only source of care available.

Now, just to give some illustrations of where I think this could cause some problems or where some objections could be raised is the hearing that we had in the State of Michigan before I moved to Texas in 2006, where I was asked to represent the Michigan State Medical Society at a hearing of the state senate to hear a piece of legislation that had been proposed which was designed to specifically protect the rights of conscience of the health worker.

And we were objecting to it, as were the hospitals and just about every health care facility, frankly, in the State of Michigan was objecting to this law because it seemed totally out of balance. It was all about the right of conscience of the health professional and there was absolutely nothing in the law about service to the patient or the needs of the patient.

So we were very concerned that this was a one-sided piece of legislation. And it struck us as we went to testify against this legislation that when asked what was the need, where were the instances that, for example, a professional had either been fired or had been forced to provide service over their conscientious objections, they in fact could not name a single instance where this happened that created a practical need for this new legislation.

All they could do was hypothetically say, "Well, down the road there might be new drugs derived from stem cell research, and that would offend many people's consciences, so we need a law today to be sure that in the future people didn't have to administer these drugs to which they might have a conscientious objection."

And another example from this hearing was one of the defenders of the legislation said it was very important to extend the right of conscientious objection to the system and not just to the individual. So it's not just a matter of personal integrity, but it extends to the system. "So, for example," said this expert, "the owner of a large business who has a conscientious objection to contraceptives should be able to say that his firm's health insurance policy will not cover contraceptives," because that would violate his own conscience. So in this case it's the firm, the corporation, and not the individual that objects to the treatment.

And I would say that this systems-level refusal makes perfect sense in some settings. So the idea of a network of religious hospitals, for example, saying our religion requires that we do not provide this procedure in any of our hospitals, to me that make perfect sense and I think that's very legitimate.

I would argue that in the case of the owner of the firm that it's mis-described as conscientious objection and it seems to me to be something quite different. I would submit to you that it's abuse of power. It's using one's financial power, in this case, to impose one's own philosophical or religious views on others of differing views, which I think is different from the exercise of one's conscience.

So I would offer some conclusions from this rather hasty set of thoughts. In cases that are reasonably analogous to our case study — the pharmacist with the prescription for the emergency contraceptive — I have tried to suggest to you that the two-promises account explains how conflicts may arise and why both promises deserve moral respect, the public collective promise of the professionals made to the patients to put their interests first, and my personal promise that I made to my special internalized group of moral mentors as to how I would behave in order to be the kind of person that I want to be as a moral being, and that fortunately a system's level attempt to resolve conflicts appears practically workable in many or even most settings.

Now, an implication that comes out of my distinction between the mild and the strong interpretations is a message for leaders of religious faith communities, I believe. And I'm a little on shaky ground talking here because I'm certainly not a theologian and have no expertise in religion, but I'll throw this out for whatever it may be worth.

It may be that your religious tradition allows one interpretation only, that the strong interpretation is the only one consistent with your faith tradition. If that's so, nothing more should be said. That's the way it is. But in many faith traditions interpretation is possible, and it may be that a strong interpretation is correct or it may be that a milder interpretation is correct, and there could be

discussion and debate within the faith tradition over which account is correct.

If the leader of the faith community encourages the health professionals who are members of that faith community to lean toward the milder interpretation, it follows as a practical consequence that social conflict will be minimized and that it will be easier for that group of providers, that group of health professionals, to adhere to both those promises that they made, both the promises to their own conscience, to their own inner voice, and the promise to the larger community to serve the patient.

To the extent that the religious leaders insist on the strong interpretation and discount the validity of the mild interpretation, one can predict that social conflict will increase, and it will be harder and harder to engineer social systems or health care systems in such a way as to revolve those conflicts. And I believe that then becomes partly the responsibility of the religious leader if there had been at least the possibility that another interpretation might have had some validity.

So what I personally hope is that in the future we will see more examples of conscientious objection dealt with by a local accommodation in the spirit of mutual respect and fewer instances where the use of political or financial power favors only one promise over the other equally important promise.

Thank you very much.

CHAIRMAN PELLEGRINO: Thank you very much, Howard . Our third speaker is Dr. Farr Curlin . Dr. Curlin.

DR. CURLIN: Thank you, Dr. Pellegrino , and I also would like to say it's a great honor to have a chance to address the Council and to be a part of this panel with my colleagues, although, as you'll see, I will disagree with them on some important levels.

Let me begin with my observations as a physician and as one who has observed the practices of other physicians. Physicians commonly refuse to provide clinical interventions that patients request even when those interventions are legal and permitted by the medical profession. These refusals are neither new nor peripheral to clinical practice.

Physicians of course refuse interventions that they believe are categorically unethical. In taking the Hippocratic Oath, physicians have for centuries sworn to refuse to provide either abortifacients or any drug or information that will be used to help kill patients. Physicians also refuse practices that they believe are ethical in some cases but not in the case at hand. For example, I believe it is ethically permissible to sedate dying patients to the point of unconsciousness if the intended and direct effect of the sedation is to relieve distressful symptoms that are refractory to other treatments. Yet in my own practice of hospice and palliative medicine, I sometimes disagree with patients, their families, or other health care providers about whether we should increase the level of sedation in a particular case.

Sometimes physicians refuse interventions that are the subject of widespread public dispute, such as abortion or emergency contraception. More often their refusals occasion little controversy. For example, surgeons refuse to operate when they believe a surgery is unlikely to be successful whether or not all of their colleagues agree. Physicians refuse requests for antibiotics or other remedies even if the patient's symptoms satisfy some threshold criteria for using these medications. Physicians may refuse requested interventions because of tangible concerns about safety or efficacy, or they may refuse because of concerns that are less tangible if no less real. Some Catholic physicians refuse to provide contraceptive medications because the Roman Catholic Church teaches that such medications illicitly separate the procreative and unitive aspects of human sexuality.

More commonly, physicians' intangible concerns are not explicitly religious. Some pediatricians refuse to provide growth hormone injections to boys who are short because of concern about crossing a line between treatment and enhancement. Internists and family physicians sometimes refuse intensive work-ups and treatment regimens for what they believe are psychosomatic syndromes, because they are concerned about being good stewards of their colleagues' time and other medical resources. Obstetrician-gynecologists who will abort fetuses with lethal congenital anomalies may refuse to abort those with Down's Syndrome or cleft palate out of concern about societal attitudes toward those with disability. Physicians refuse patient requests even when patients are informed, even when threshold medical criteria are met that would generally justify the intervention, and even when physicians are aware that some of their colleagues would disagree with their refusal.

So to say a refusal is conscientious is simply to say that it is based on a physician's best judgment about what he or she ought to do in a given case. In its recent opinion, the ethics committee of the

American College of Obstetricians and Gynecologists wrote that, "An appeal to conscience would express a sentiment such as 'If I were to do X, I could not live with myself. I would hate myself. I wouldn't be able to sleep at night.'" Professor Brody mentioned a notion that my grandmother would turnover in her grave if I did this.

I would suggest that conscientious refusals need not be so dramatic. Rather, they are merely refusals based on what physicians believe are good reasons. In a morally pluralistic society, such reasons will not be persuasive to all, but they will be intelligible and plausible. And I should note that in virtually every case of which I'm aware, people do give reasons. I have not seen people, at least in public discourse, say "I can't do this just because my conscience says so." Rather, they say "I can't do that in good conscience because" and then what follows as a reason.

Now, critics sometimes suggest that health care professionals' stated reasons for refusing particular interventions are specious and hide unspoken prejudices. I was encouraged to hear Professor Brody note that we should presume good faith about people's objections. In the essay that was in the briefing booklet, Professor Brody and Susan Night say they "suspect that what the conscientious pharmacist" who refuses emergency contraceptive pills — what that pharmacist actually objects to but does not have the nerve to say outright is the possibility that a woman can engage in sexual activity without having to face the moral consequences of her potentially illicit act.

Now, it goes without saying that physicians who act capriciously are not acting conscientiously, yet the scare quotes around the terms conscientious and moral suggest, I think, that the authors do not acknowledge or take sufficiently seriously genuine moral disagreement about postcoital contraception.

To say that conscientious refusals are central to the practice of medicine is not to say that every conscientious refusal is justified. Father Paris talked about that in some detail earlier. A conscience that is malformed or misinformed will err. I'll give you a clinical example. A conscientious physician may fail in his duties to relieve a patient's debilitating pain because he has not been trained to pay close attention to and work hard to address pain. Alternatively, he may fail because he incorrectly interprets the patient's behavior as drug-seeking and malingering. The conscience as a human faculty is both limited and fallible. Yet, however fallible, conscientious refusals are, I think, a logical and necessary consequence of physicians exercising discernment or clinical judgment.

It has long been recognized that medical decisions cannot be reduced to doing what patients want or even to clinical algorithms, rules of thumb, and scientific data. This is in part because the application of medical science always embodies and expresses normative ideas about the body and what it means to be human, to flourish, and to fulfill our obligations to one another. Science can neither provide these ideas nor settle disagreements about them. In addition, even if there were agreement about these underlying moral issues, physicians still must consider and weigh up innumerable different factors, probably many of them unconsciously, in order to discern how best to seek the health of a particular patient in a particular context, all things considered.

This task is almost always attended by ambiguity and uncertainty, and it requires what Aristotle called *phronesis* or practical wisdom, which in the practice of medicine has been called good clinical judgment. If physicians are to exercise clinical judgment in seeking their patient's health, they will necessarily refuse some patient requests.

So, with respect to the present controversies, it cannot be that conscientious refusals per se are ethically problematic. What we are after are criteria by which to distinguish those refusals that are consistent with physicians' professional obligations from those that contradict those obligations. To find such criteria, we have to figure out what in fact physicians are obligated to do.

We might start with the obligation, as Dr. Pellegrino put it at the end of the morning session, the obligation that has been self-evident to people from virtually every culture and moral tradition throughout the centuries; namely, the obligation to care for the sick so as to preserve and restore their health. The Hippocratic Oath states, "Into whatever houses I enter, I will go into them for the benefit of the sick," and this universally recognized obligation still provides a powerful criterion by which we can discern that some refusals, however conscientious, are incompatible with good medical practice.

For example, the physician who refuses to care for patients with HIV because of antipathy towards homosexuals or for black patients because of racial prejudice or for criminals because of revulsion at their crimes thereby violates, in my understanding, his or her constitutive professional obligations to seek the health of patients precisely because they are sick without regard to their other characteristics. However, this obligation to seek health does not provide a criterion by which to

condemn the sorts of conscientious refusals that have stirred contemporary controversies.

Rather, as biomedical science has expanded, it has made possible many uses of medical technology that are not so obviously directed to preserving and restoring health. Examples include terminal sedation, growth hormone for short children — or, as we have learned, for professional athletes — cosmetic surgery, most assisted reproductive technologies, elective abortion, and others. Yet the paradigmatic example of such interventions and the one that continues, not surprisingly, to animate disputes about conscientious refusals, is contraception.

In 1979, twenty years after the FDA approved the first oral contraceptive, Mark Siegler and Anne Dudley Goldblatt wrote the following: "The oral contraceptive medication was the first prescription drug that was and is, in effect, a self-prescribed treatment. Patients — i.e., medical consumers desiring elective medication — demanded that physicians prescribe the contraceptive pill. Other popularly self-prescribed medications soon followed and came to be seen as appropriate solutions for treatments for problems previously considered individual or social concerns, but in any case not biological abnormalities or specific diseases."

It is not surprising that physicians became the purveyors of these technologies. They had the scientific expertise and the legal authority to manipulate the body. However, from the beginning many within the profession have argued that physicians have no business pursuing ends other than health, and despite the widespread use of these technologies some have always refused to provide them. For a long time such refusals were uncontroversial. The medical profession has traditionally given wide latitude to physician discretion in areas of disagreement. Professional codes have consistently stated that physicians are not obligated to satisfy patients' requests for interventions that the physician does not believe are in the interest of the patient's health. In this respect, and notwithstanding claims to the contrary, physicians who refuse to provide such technologies today are not claiming new freedom from old professional obligations.

Physician refusals have become newly controversial, I would argue, because the emergence of a new technology — in this case postcoital contraceptives — has intensified an old concern about patients having access to reproductive services. For better and worse, physicians do have exclusive license to administer technologies by which millions of Americans have come to order their lives — and, in all fairness, have come to order their lives in a conscientious fashion. With respect to most of these technologies, if one physician will not provide what a patient seeks, the patient can go to another physician who will. The patient incurs relatively modest costs as a result of the physician's refusal.

Postcoital contraception is different. It works only if administered within a brief window of time. If a woman seeks emergency contraception after intercourse and her physician refuses to prescribe it or her pharmacist refuses to dispense it, she may get pregnant when she would not have otherwise. In response to reports of such refusals, a chorus of different writers has argued that doctors and pharmacists must provide or facilitate access to all legal and professionally accepted medical technologies, notwithstanding their moral objections.

Now, here I'm going to part ways with my colleagues here in that these arguments lean heavily on a moral distinction and tension between the personal and the professional. That's right in the title, for example, with Professor Brody's talk. Whether this tension is posed as personal moral values versus professional ethical obligations or personal conscience versus professional conscience or, in the case Professor Brody described, duties related to personal versus professional integrity.

Health care professionals who refuse to provide what patients request, the arguments go — or, to be fair, refer for or facilitate access to those things at patients' request — thereby allow their personal considerations to trump their professional obligations.

Unfortunately, this pitting of personal versus professional tends to beg the relevant moral question, because unless and until we can specify our professional obligations, we cannot know whether they are being violated, nor can we know which obligations are merely personal.

In these debates, it seems to me, everything turns on how we define the substance of our professional obligations, because at the heart of every controversy about physician refusals lies a debate about what medicine is for. As biomedical science generates technologies that people desire to use that they highly value, questions are raised as to whether those uses are really directed at health objectively defined. If not, then some argue for a broadening of the concept of health to justify the use of the new technology or they argue that physicians are obligated to pursue other goals in addition to health.

In his 1975 essay "Regarding the End of Medicine and the Pursuit of Health," Leon Kass noted, "It is

ironic, but not accidental, that medicine's great technical power should arrive in tandem with great confusion about the standards and goals for guiding its use. When its powers were fewer, its purpose was clearer." Several years later, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research — quite a mouthful; I'm glad that's been revised — echoed this observation. Citing Siegler, the Commission wrote in 1982:

"Judgments of conscientious persons have become divergent and perplexed and societal consensus does not exist. No longer are the proper ends and limits of health care commonly understood and broadly accepted; a new concept of health care, characterized by changing expectations and uncertain understanding between patient and practitioner, is evolving. The need to find an appropriate balance of the rights and responsibilities of patients and health care professionals in this time of change has been called the critical challenge facing medicine in the coming decades." And if today's forum is any indication, it seems the challenge remains.

Those who frame conscientious refusals, I would argue, as a conflict between personal values and professional obligations thereby take one side in a debate they rarely acknowledge. For example, Chervenak and McCullough, two very prominent ethicists in the area of obstetrics and gynecology, claim that conscientious refusals violate physicians' duty to protect and promote the health-related interests of patients. Professor Brody and Susan Night in their essay in the booklet claim that pharmacists who refuse to make arrangements for patients to receive emergency contraception violate their professional duty to dispense medications that are, in the authors' terms, medically indicated for the patients' condition. The ethics committee of the American College of Obstetricians and Gynecologists also criticizes those who fail to provide medically indicated treatments. Unfortunately, these claims beg the question they propose to answer, because they do not address disagreements about whether the interventions in question are really health-related. To put it another way, we cannot know whether something is medically indicated unless we know what medicine is for, whether, for example, the patients' condition is one which medicine properly treats.

In these critiques, if authors do not beg physicians' obligations, they often assert obligations that are themselves highly disputed. For example, Chervenak and McCullough criticize physicians who disclose the reasons for their conscientious refusals to patients. They argue that such disclosures violate an ethical consensus that physicians should be nondirective in their counsel to patients. Yet, we can see that no such consensus exists by turning to the paper on enhanced autonomy by Professor Brody and Timothy Quill who there argue that physicians fail to use their power appropriately when they withhold their guidance and that this failure reflects a misunderstanding about the moral requirements of respecting patient autonomy.

Now, the ACOG Ethics Committee opinion also interprets uncontroversial physician commitments, I would argue, in novel and controversial ways. For example, the Committee invokes respect for patient autonomy but without explanation amplifies it to imply respect for the choices patients make and a "fundamental duty to enable patients to make decisions for themselves." Moreover, the Committee replaces the objective references for the concepts of health and harm. It asserts that harm cannot merely be measured with reference to bodily health but also with reference to "well-being as the patient perceives it." It does not attempt to demonstrate that physicians must provide particular interventions if they are to preserve and restore patients' health. Rather, and in a telling use of language, the Committee asserts that physicians are obligated to provide — and here again I'll quote several of these phrases: "to provide reproductive technology..., health resources..., professional services..., standard reproductive services that patients request..., and safe and legal reproductive services..."

A comprehensive treatment of the merits and weaknesses of each of these claims is beyond the scope of my comments. It's perhaps enough to point out that there is even less consensus about these purported physician obligations than there is about the controversial practices which the physicians are refusing to provide. Moreover, and I think more problematically, these purported obligations depend on a provider-consumer ideal for the doctor-patient relationship that has been widely criticized as being insufficient for, and even corrosive of, the practice of medicine. Siegler and Goldblatt drew the connection in 1979, warning that the demanding patient presents a serious danger to clinical medicine. They continued: "The demanding patient denies that the physician's responsibilities and expertise have any relevance except insofar as this coincides with the patient's desires. The demanding patient inverts the traditional model and makes the physician a passive agent. The patient proposes; the physician provides. The physician becomes a technician practicing under the direction and control of his or her client."

In 1982, the President's Commission report titled *Making Health Care Decisions* echoed Siegler and Goldblatt's concern, and over the ensuing three decades a series of influential clinicians and ethicists who disagree on a great many other substantive moral questions have agreed that the pendulum has

swung too far away from physician paternalism toward an emphasis on patient autonomy that amounts to what the President's Commission called "patient sovereignty."

In the paternalism model, the physician ordered, the patient obeyed. After the patients' rights movement, the physician proposed, the patient chose or gave consent. In the patient sovereignty model, or what Quill and Professor Brody called the independent choice model, the patient proposes, the physician provides. The physician has effectively lost both moral agency and responsibility.

Arguments for reining in conscientious refusal depend on this latter model being the right one. Only if the physician-patient relationship is one of provider-consumer or technician-client can patients' legal right to seek biomedical interventions imply that physicians have a professional obligation to provide what patients seek. Only then can respect for autonomy imply nondirective counseling and a fundamental duty to enable patients to make decisions for themselves. Only then can informed consent be redefined as informed choice. Only then can physicians' obligation to care for the sick be exchanged for an obligation to provide health care services toward the goal of maximizing well being as the patient perceives it.

Some would welcome the prospect of physicians answering to their patients regarding what is good for them. After all, if these controversial technologies are not directly related to restoring health, they are at least medical commodities — health care services, to use the prevalent language — and physicians have no particular expertise or standing to determine how autonomous individuals put non health-related commodities use. An independent choice model for the doctor-patient relationship would improve access to these services while reducing patients' risk of surprise and embarrassment. The model would bring simplicity, efficiency, choice and control. If some physicians do not like providing these services, they can quit or find another clinical specialty.

That is one option. We have a choice which will be made through all of the instruments of politics.

My point here is that it is a consequential choice. The profession can continue to ask its members to commit themselves to an objective goal, namely health, that is not subject to wholesale revision. If this route is taken, the profession must allow, from my understanding, conscientious refusals where there is reasoned dispute about whether an intervention is consistent with that goal. Or the profession may constrain the scope of conscientious refusals and move toward a provider-consumer model in which physicians' moral and clinical judgment is irrelevant to their task of providing what patients lawfully seek. We cannot have it both ways.

And to close I'll describe three logical — I think logical, if unintended — consequences of taking the latter route to argue that if we choose it we may lose more than we gain. First, any policy that constrains the scope of conscientious refusals thereby erodes the possibility of conscientious practice. It seems obvious that patients want their physicians to be conscientious insofar as possible. Few would respect or desire the care of physicians who are in the habit of doing things they know to be unethical. Fortunately, individuals from virtually all moral traditions and communities can conscientiously and enthusiastically commit themselves to caring for the sick. That is one reason why the profession of medicine has been able to maintain both prestige and a semblance of unity in a society made up of many different moral communities. Yet if physicians must be willing also to participate in contraception and sterilization, those who believe what the Roman Catholic Church has taught for centuries about the human body and sexuality, and those who believe that physicians should aim at health and nothing else, will no longer be able to practice conscientiously.

If physicians are required to refer patients to abortionists — to those who provide abortions — when requested, those who believe that such referral makes them complicit in a gravely immoral action will have to quit. And so the process goes.

Every time the scope of conscientious refusal is narrowed, the pool of people who can be conscientious physicians is reduced. Eventually, the only ones left will be those who are willing to make all legal medical technology available to be used by patients according to their own judgment.

Second, by requiring physicians to do what patients request, we set physicians and patients at odds with one another. Professor Brody and Timothy Quill argue that in the independent choice model, the physician as a person with values and experience has become an impediment to rather than a resource for decision making. I would add that the patient also becomes a moral threat to the physician, particularly if restrictions on conscientious refusals take on the force of professional or legislative policy. Physicians will then wonder when their patients might, with the backing of legal sanction, ask them to act against their own understanding and do that which they believe is unethical.

Third, patients will lose the basis for trusting that their physicians are committed to their good. Benjamin Franklin once said, "If we restrict liberty to attain security we will lose them both." A similar dynamic is at work with respect to the practice of medicine. If we restrict professional autonomy and physician discretion to preserve patients' interests, we will lose both. Why would that be?

Well, under the old model of paternalism, patients could trust that physicians had committed themselves to the patients' best interests, albeit in a limited way — only insofar as those interests included restoring and preserving health. The patients' rights movement and the rise of the doctrine of informed consent qualified and delimited physicians' commitment to pursue health. Out of respect for persons, it was decided — I think rightly — that physicians are to act only with the permission of the patient. Because health is a relative and not an absolute good, patients are authorized to relativize that good to other concerns such as not being overburdened by medical technology. Yet within these limits, physicians remain committed to health. In the enhanced autonomy model of Quill and Brody, the deliberative model of Emanuel and Emanuel, and the physicians' conscience model of David Thomasma, physicians are responsible for thinking, using discernment, making judgments, providing counsel, and even seeking to persuade patients to make the choice the physician believes is best.

Models that support constraining conscientious refusals differ in a fundamental way. In them patients not only relativize the good of health to other concerns but also define which goods physicians will seek. Patients gain technicians, it seems to me — technicians who are committed to cooperation, and they lose healers committed to health. They gain control over physicians, but thereby divest physicians of responsibility. As a result, physicians can wash their hands of patients' decisions so long as the physician gives accurate information and provides technically proficient health care services.

So one cannot merely constrain the scope of conscientious refusals and leave all else the same. Policies that devalue conscientious practice and/or make it more difficult reduce that which makes the practice of medicine its own reward: the confidence and conviction that what one is doing is very good. This morning Dr. McHugh described working long hours for little pay and yet being very happy at it. Dr. Hurlbut described watching his father spend a portion of each week caring for patients who could not pay for that care and finding that work immensely rewarding and satisfying. If I remember his comments correctly, Dr. Hurlbut you said it stirred in you a sense of the nobility of the practice of medicine.

It seems to me that if physicians surrender their commitment to do only that which they believe is good for their patients' health, they will also surrender the nobility, joy, and other intrinsic rewards of medical practice. Their morale will decline, and I would argue has already declined precisely because the practice of medicine has been literally demoralized.

There is a better way, I think, that has been iterated again and again by the clinicians and ethicists that I have already mentioned. That way involves conscientiousness and candor on the part of physicians. Where there is ambiguity or dispute about whether a particular practice belongs in medicine, physicians and patients have a respectful and candid discussion so that they can negotiate an accommodation that does not require either to do what they believe is unethical. In this model, physicians would not feign moral neutrality but instead would tell their patients frankly what the options are, which ones the physician is willing to provide, and why the physician recommends one over another.

The scope of permissible accommodations will have to be set through the political process. But I would echo the conclusion reached by the President's Commission in 1982, which is that considerable flexibility should be accorded to patients and professionals to define the terms of their own relationships. This model would encourage policy accommodations that provide reasonable access to controversial technologies without asking physicians to provide interventions to which they object. For example, before the FDA approved over-the-counter sales of postcoital contraceptives, some states had bypassed the need for a cooperating physician by allowing pharmacists to dispense the drug without a prescription. In a forthcoming essay in *Theoretical Medicine and Bioethics*, Armand Antommara argues for and provides numerous other examples of policy accommodations that promote patients' interests and access to medical technologies without diminishing physicians' interests in maintaining moral integrity.

In conclusion, unless and until consensus is forged regarding the ends of medicine, refusals of controversial practices cannot be shown to violate physicians' professional obligations. In the meantime, the practice of medicine should be open, I think, to anyone who is willing to unreservedly commit herself to caring for the sick so as to preserve and restore their health. In light of deep moral

disagreements in our society about the scope and limits of medicine, the profession should invite differences in practice so long as physicians are candid about their practices so that patients can effectively participate in medical decisions. Conscientiousness, when accompanied by candor and respect, gives a limited ground for patients to trust physicians as they work out accommodations in the face of genuine disagreement about how to apply medical science toward the patient's good.

Thank you.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Curlin, and thank you also to the other panelists for being so very, very punctual and bringing us to the point of our break. We're going to break now and then on return at 3:45 we will hear from Dr. Robby George, who will open the discussion for the rest of the Council members.

(Session 3 continued)

CHAIRMAN PELLEGRINO: I think we'll move ahead. Robby, would you introduce the discussion?

PROF. GEORGE: Thank you very much, Dr. Pellegrino, and thanks very much for the opportunity to offer an opening comment and lead the discussion. My comment will focus mainly on the ACOG Committee Opinion No. 385 of November 2007 on "The Limits of Conscientious Refusal in Reproductive Medicine."

The critical things — and I'm very critical of this opinion — but I have to say were reinforced in my saying them by Dr. Lyerly's presentation this morning. And so I do hope that Dr. Lyerly will be given an opportunity as the other panelists will be to challenge what I have to say because it is highly critical.

DR. ROWLEY: Well, she's not here to hear them, so I think that you have to wait until she comes.

PROF. GEORGE: Absolutely fine with me.

CHAIRMAN PELLEGRINO: She's here. Dr. Lyerly is here. She's just been in the wings.

PROF. GEORGE: Dr. Lyerly, while you were out I said that my comments are going to be focused on the ACOG report of November 2007, "The Limits of Conscientious Refusal in Reproductive Medicine," and my comments are going to be highly critical. So I expressed a hope that you'd be given an opportunity to respond to them and to challenge me if you'd like. The same for, of course, the other panelists.

The first thing to notice about the ACOG Committee report is that it is an exercise in moral philosophy. It proposes a definition of conscience, something that cannot be supplied by science or medicine. It then proposes to instruct its readers on, "...the limits of conscientious refusals describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care."

Again, knowledge of these limits and values, as well as knowledge of what should count as the ethical provision of health care, are not and cannot possibly be the product of scientific inquiry for medicine as such. The proposed instruction offered here by those responsible for the ACOG Committee report represents a philosophical and ethical opinion — their philosophical and ethical opinion.

The report goes on to, "outline options for public policy," and propose, "recommendations that maximize accommodation of the individual's religious and moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve."

Yet again notice that every concept in play here — the punitive balancing, the judgment as to what constitutes an imposition of personal beliefs on others, the view of what constitutes health care or reproductive health care, the judgment about what is deserved is philosophical, not scientific or, strictly speaking, medical.

To the extent that they are medical judgments even loosely speaking they reflect a concept of medicine informed and structured, shaped by philosophical and ethical judgments. Those responsible for the report purport to be speaking as physicians and medical professionals.

The special authority the report is supposed to have derives from their standing and expertise as physicians and medical professionals, yet at every point that matters, the judgments offered reflect their philosophical, ethical, and political judgments, not any expertise they have by virtue of their

training and experience in science and medicine.

At every key point in the report their judgments are contestable and contested. Indeed they are contested by the very people on whose consciences they seek to impose, the people whom they would, if their report were adopted and made binding, force into line with their philosophical and ethical judgments or drive out of their fields of medical practice. And they are contested, of course, by many others. And in each of these contests a resolution one way or the other cannot be determined by scientific methods, rather the debate is philosophical, ethical, or political.

Lay aside for the moment the question of whose philosophical judgments are right and whose are wrong. My point so far has only been that the report is laced and dependent upon at every turn philosophical judgments. I've not offered a critique of those judgments, although anyone who cares to can find plenty of criticisms in my work of those judgments. But lay that aside for now.

The key thing to see is that the issues in dispute are philosophical and can only be resolved by philosophical reflection and debate. They cannot be resolved by science or methods of scientific inquiry. The committee report reflects and promotes a particular moral view and vision and understandings of health and medicine shaped in every contested dimension and in every dimension relevant to the report's subject matter, namely the limits of conscientious refusal, by that moral view and vision.

The report, in other words, in its driving assumptions, reasoning, and conclusions is not morally neutral. Its analysis and recommendations for action do not proceed from a basis of moral neutrality. It represents a partisan position among the family of possible positions debated or adopted by people of reason and goodwill in the medical profession and beyond. Indeed, for me, the partisanship of the report is its most striking feature.

Its greatest irony is the report's concern for physicians' allegedly imposing their beliefs on patients by, for example, declining to perform or refer for abortions — or at least declining to perform abortions or provide other services in emergency situations and certainly to refer for these procedures. The assumption here, of course, is the philosophical one that deliberate feticide is morally acceptable and even a woman's right.

But lay that aside for now. Of course, the physician or the pharmacist who declines to dispense coerces no one, though I think that Prof. Brody and I would have a debate about that. He or she, that physician or pharmacist, simply refuses to participate in the destruction of human life or human life in utero.

By contrast, those responsible for the report and its recommendations evidently would use coercion to force physicians and pharmacists who have the temerity to dissent from their philosophical and ethical views to either get in line or go out of business.

If their advice were followed, they had their way, their fields of medical practice would be cleansed of pro-life physicians whose convictions required them to refrain from performing or referring for abortions. The entire field would be composed of people who could be relied on either to agree with or at a minimum go along with their convictions, those of the report's authors, on this most profound of moral questions upon which reasonable people of goodwill disagree, yet must somehow find a way to live together in peace and discuss their differences with civility and mutual respect.

And, of course, abortion here is simply the most profound of the examples. I do agree with Dr. Lyerly that there are many other issues that are at stake besides abortion, though less profound in most cases than that issue.

Now, I'm on the pro-life side of the question, but one need not share my view to see that the report proposes to impose its morality, the morality of those responsible for the report, on others if these were accepted as binding norms of ethics in the field.

It won't do, in my opinion, to say that what is being imposed for imposition on dissenters here is not a morality, but merely good medical practice for it is not science or medicine itself that is shaping the report's understanding of what is to count as good medical practice. It is philosophical and ethical judgments, judgments brought to medicine, not judgments derived from it.

Whether an elective abortion or an in vitro procedure or what have you counts as health care as opposed to a decision about what one desires or what lifestyle choices one wishes to make cannot be established or resolved by the methods of science or by any morally or ethically neutral form of inquiry or reasoning. One's view of the matter will reflect one's moral and ethical convictions either way — either way.

So the report's constant use of the language of health and reproductive health in describing or referring to the key issues giving rise to conflicts of conscience is at best — at best — question begging.

Let me close these remarks with yet another irony as I see it. The report in defending its proposal to compel physicians in the relevant fields to at least refer for procedures that physicians may believe are immoral, unjust, and even homicidal said that such referrals — and I quote — "need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgement of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees."

So suddenly it's the case that the underlying issues at stake, such as abortion, are matters of widespread and thoughtful disagreement, and I agree with that. And it becomes clear from the report that we should show respect for the moral sincerity of those with whom we disagree. But it seems to me that it follows from these counsels that thoughtful and sincere people need not agree that abortion, for example, is morally innocent or acceptable or that there is a right to abortion or that the provisions of abortion is part of good health care or is health care at all, at least in the case of elective abortions.

But then what could possibly justify — what justification could there possibly be for the exercise of coercion to require thoughtful, morally sincere physicians who believe that abortion is a homicidal injustice that they either make a referral for it, a procedure that they reasonably regard as the killing of a child in utero, or leave the practice of medicine as the other alternative.

The report's "my way or the highway" view of the thing is anything but an acknowledgement of the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of those with whom one disagrees. Indeed, it is a repudiation of it.

Thank you.

CHAIRMAN PELLEGRINO: Thank you, Robby. We'll now give an opportunity for the panelists to respond in any way they wish. Dr. Lyerly, would you like to go first?

DR. LYERLY: Well, thank you very much for your thoughtful comments, for reading the position statement so carefully. I neglect that in my deciding that I'm not going to be able to respond point by point and particularly to your concerns because in my agreement to attend and speak at this meeting, I have been — I've agreed also not to discuss the opinion 385 specifically. So I can only speak on my own behalf.

But I will say, though, as a matter of fact is that ACOG's Committee on Ethics is not just a group of physicians who get together and make moral judgments. We have people trained in philosophy on our committee, we have people trained in public health, and we have physicians with a great deal of moral wisdom. So I think the concern about whether this is a scientific judgment or a moral judgment should be considered in light of the fact that the committee is a diverse committee both in terms of expertise and in terms of views about the sorts of issues that you brought up. Thanks.

CHAIRMAN PELLEGRINO: Dr. Brody.

PROF. BRODY: I guess I would prefer to pass at this time, if I may, and actually try to hold any comments to questions directed more at what I said specifically here.

CHAIRMAN PELLEGRINO: Dr. Curlin.

DR. CURLIN: Well, I'll maybe just raise one issue that might be the first question to Prof. Brody, which is why — you drew a distinction between mild and strong interpretations of judgments of conscience or conscientious refusals. You said a mild one would imply something like standing aside and that a strong would imply some sort of — I forget the terms you used, but active resistance to or incumbering patients' choices, and I was curious why you put the refusal to refer — this relates somewhat to Prof. George's comments — why you put the refusal to refer in the strong category. How does it constitute an active prevention of someone else obtaining what they seek?

PROF. GEORGE: Okay. Thank you. I'm not happy with those terms. I grasped at something to call it, and if somebody could come up with some better terms, I would be grateful. There's a spectrum here, and I think it's a spectrum that — I think I saw a slide in Dr. Lyerly's presentation that had an arrow with a thing at both ends of the arrow I think that got at somewhat the same idea. But there's clearly a spectrum. It's not an either/or.

And at one end of the spectrum I was thinking of actions that primarily involved the individual health professional standing aside, but that was the least amount of interference with the patient getting the service that the patient sought, and at the other end of the spectrum the patient was most inconvenienced or prevented or coerced from having that service provided by the action of the health professional.

So the referral was more in the middle of the spectrum. It was not at the far end of the spectrum, but it clearly put an impediment in the way of the patient getting the service. If the patient was not as familiar with other sources of care or other sources of service then the patient would be relatively more dependent on this provider letting the patient know that these things existed or that they could help the patient get there.

To the extent that the patient is very well informed and is very knowledgeable and has the means to go around and to find out other things, it would be the least amount of impediment. So it might be patient specific or even social class specific in terms of how much or how little of an interference that was with the patient's ability to obtain the service.

CHAIRMAN PELLEGRINO: Dr. Meilaender and Dr. Elshtain .

PROF. MEILAENDER: I want to try to just think about a couple of theoretical questions. I'm more interested in them for the moment than in the particular issues that get debated here. And I have a question for Dr. Lyerly and one for Dr. Brody . But first I have a friendly suggestion, and that is that the use of the language of imposition in these contexts is always misleading. It suggests the need for complicated arguments about entitlements that haven't been made.

And if I'm a person who declines ever to use force against anyone else and you need me to do it in order to protect you and I say, "I'm sorry, that's something I never do," it would be very peculiar to describe me as having imposed my values on you. It might be too bad from your perspective, but I haven't imposed them on you anymore than you would be imposing on me if you tried to persuade me to do it. So I just think the language of "imposition" should be gotten rid of.

But my theoretical interest — it's really a very old question. It's just a form of the "Can a good man be a good citizen" question that philosophers have been thinking about for a long time. And I have a particular question for Dr. Lyerly and one for Dr. Brody .

For Dr. Lyerly , you gave us a slide about different ethical considerations. One of them was conscience, but then there are others — health, fairness, and respect. And these are all the values in play in the situation, and they are somehow to be balanced or we're to decide relative weights or something, and I would like to hear you say more about how one does that, how this procedure of balancing or weighing takes place. That's my question for you.

And for Dr. Brody, you had — the fascinating question you raised under your slide on professional integrity about a professional elevating the — in this case the patient's needs above his own interests, and then you said does one's own interest include one's personal integrity. But then you confused — and I think that's — it's like, you know, "Should I be prepared to go to hell in order to help somebody," a question which theologians have actually discussed.

But you gave the, to me, puzzling example of physicians who should be willing to risk their own lives in an epidemic, for instance, to do it, and then you said, you know, if you'd risk your life, why wouldn't you risk your integrity.

But I thought the reason for a physician being willing to risk his life in an epidemic was precisely that he didn't think staying alive was the most important thing, that there was something else that was morally more compelling and obligatory even than preserving his existence. And that would have something to do with the personal integrity that you seem willing to think may be — one should be willing to set aside in embracing what one thinks is evil. And so I'd like you to just sort that one out for me a little bit more.

DR. LYERLY: Thank you for your question. I wish had a truly formulated answer to it because the framework that I presented really came to me as I was thinking through considerations from the perspective of the patient, which is I think a perspective that is often not represented in fine grains to the degree that considerations about conscience itself in the profession are.

So as I was thinking about the patient-centered considerations, they really fell into three categories. Again, one was questions about welfare. So the harms that might result from the decisions of providers not to inform, refer, or provide services they find morally objectionable, and I gave some examples of those potential harms. Some may be palpable, measurable harms that we as physicians

can see. Some may be express harm. So that's one category that ought to be considered when we're thinking broadly about the category of patients, the effect of conscientious refusals on patients.

The second is questions about justice and how the decisions that providers make that lead to differential access to different — to goods and services. So the degree to which the decisions of providers lead to differential access — how do we measure that.

And the third is questions — and I think it's really — as you said it's difficult to find the correct word, and I have been searching for one and trying different ones on. You know, some might call it respect for autonomy. Some might think more narrowly, especially when we consider questions of reproduction about bodily dominion, so deciding whether you can control what happens to your body, what to die for, et cetera.

So those are sort of three areas that I think there may be different economies with which to measure them. So, again, theories of justice can help us with the differential access questions. Other theories about utility measurement or welfare can help us with the questions about harm to patient health.

But I think the third question, questions about bodily dominion, are really, really difficult ones. They'll probably need a theory unto themselves. But I think it may be helpful to think about them separately as we're balancing. You know, balancing acts are always difficult.

Beauchamp and Childress worked for years to talk about how you might balance principles. So that's not something I personally have worked out, but my hope that as the committee thinks through these problems that those categories would be helpful distinctions for the applications of theory.

PROF. MEILAENDER: I don't want to prolong, but I guess I'll go on record as saying I think that the image or metaphor or whatever we want to call it, the balance, is entirely uninformative. It doesn't actually tell us anything about what we're being asked to do in thinking about these things, and it's not surprising, therefore, that the way we balance them turns out to be drastically different from one person to the next. It's sounds scientific, but it's not.

PROF. BRODY: I actually totally agree with you that the example of the risking of one's life in the face of an epidemic threat may be more misleading than informative in that case. I raised it purely to pique the person's interest to go further into it and not with the idea that I thought it was any sort of conclusive argument.

And I think that if we were to plumb this sort of toward the bottom, we would need — in addition to our theoretical account of professional integrity, we would need a theoretical account of the physician's self-interest.

And I have looked at the literature to try to find that account of the physician's self-interest because I believe that ultimately if we're going to teach our medical students that in order to serve the patient you have to put the patient's interests — which Dr. Pellegrino reminded me needs careful definition — just what are those interests — above to some extent the interests — to some degree, at least, the interests of the physician or the health provider, what does that mean. And until you can define both sets of terms, I don't think you've gone very far theoretically.

I have been struck by how often the appeal to professionalism and altruism is completely uninformed by that account of what are the legitimate interests of the provider against which — which are to be put in second place. So I've tried to inform myself on this issue and, frankly, had a hard time with it. I don't know where that theoretical account lives.

So if somebody knows that, please tell me. Like, for example, how much money is a reasonable amount of money for physicians to make so that if they make more than that, they're greedy and they're putting their interests ahead of their patients' and if they make less than that, they have a legitimate grievance? How do we draw that line? How do we even think about that? I don't know of any ethical literature on that subject.

Please come to Galveston in November 5th to 7th — not now, because November, I hasten to say, is after the hurricane season — and we'll be doing a conference on the physician's duty to treat in the face of epidemic threats, and I hope we'll talk about that, because I think it's a very, very deep and troubling question and I don't believe the existing literature has as yet put the lid on it.

But certainly it's the case that we could — one reason to give up your life or to risk giving up your life is because your professional integrity seems to require it in order to serve the patient. Another reason to give up your life or risk giving up your life is because your personal conscience requires it or your faith commitments require it. That's certainly . So you could have different reasons why you

might be obligated to risk your life. And so, yes, I absolutely did not prove anything by throwing that example out, other than to just, as I hoped to say, "This needs to be explored more."

CHAIRMAN PELLEGRINO: Dr. Elshtain .

PROF. ELSHTAIN: Well, I want to begin by thanking the three of you for your very challenging presentations and also for your very obvious concern for the people that you treat and that you teach. I want to raise a question or develop an issue that Prof. George raised in his commentary, and that has to do with whether we are not often faced with a particular rather comprehensive morality that refuses to name itself and that is often presented in the guise of a kind of neutral look at the question, because I think that's often what's going on when we get a positioning sort of from the point of view of those who, in a rather neutral way, want to look at medical and scientific questions without the sort of taint of extraneous moralities is often presented as, again, a scientific view or a kind of neutral view as between competing possibilities, morally speaking, when, in fact, it is not that at all.

Now, there's a mass of literature by now. It's been accumulating over 20 years criticizing this neutrality argument, most of it written by liberal political philosophers, not conservative political philosophers. I'm thinking of people like Michael Sandel , people like Charles Taylor , William Galston , and a number of others.

And I think what these folks would say is that it's much better to have these moralities unpacked and laid out than to assume we have a sort of neutral view and then we've got a partisan view of some kind and that the neutral view somehow, the sort of scientific view, has to constantly take care that the partial or sectarian view doesn't insinuate itself.

And let me give you, Dr. Lyerly , some examples from your presentation that I think are illustrative of what I'm saying, that there's a morality involved here. I'm not saying that's wrong. I'm saying that it needs to be unpacked, understood, and named.

In your discussion of the pro-life woman with, I believe, pulmonary hypertension — was that the issue, the health issue? And you indicated that her physician, being himself or herself pro-life, might not raise for her the possibilities of or explain to her the possibilities of abortion given the health conflict that she has.

And, again, it occurred to me that in calling her pro-life, you already presuppose a pro-choice position. The pro-life position came into being in response to the pro-choice position. So we cannot assume this woman knows nothing about the alternatives.

So it seemed to me that what was, again, sort of percolating in here was, again, a particular view of the physician, of the patient, of morality that wasn't being put forward and instead it was seen as a kind of clear-cut case, which it clearly is not, of a patient not being well-informed. But, again, to call herself pro-life, as you describe her, means that she certainly is aware of an alternative.

In the example of — I believe it was the lesbian woman who came in for — was it an IUD? It was for some kind of reproductive — yes. And there again it seems to me that what we have is a situation — with everyone's views on those sorts of issues, we have a situation where a patient is coming in with an expressed desire that so far as I can tell has very little to do with what we ordinarily consider medicine or health.

It's a desire that turns on a particular understanding of the self, a particular understanding of ethical and social relations, a particular understanding of where physicians should be in relation to patients' articulation of what it is they want.

So, again, an example, but lifted out of this whole world view, and I don't think it helps us very much. It's better to articulate the cluster of presuppositions that lead to this kind of instance, this kind of example. So more clarification on that I think would be extraordinarily helpful — you know, what kinds of moralities are we talking about here, who's imposing what on whom?

Although I agree with my colleague, Dr. Meilaender, that the language of imposition is tremendously misleading, because no society has ever existed anywhere at any time that didn't mandate certain things and that was not coercive in the implication of those things. Every time we enforce a law, there's an element of coercion. So I think we have to be clear about that.

There are all kinds of things that you and I are prohibited from doing every single day, and we're glad that society imposes for the most part. I've got to stop at a red light. It's an imposition. So I think the language of imposition isn't tremendously helpful. We need to think of another way of talking about

this because we cannot live with the issue of some kinds of mandates and certain forms of coercion. Liberal societies try to reduce the coercion as much as they can, but it's there, although we often don't like to talk about it very much.

Dr. Brody, in your case, I wanted to just — a couple of questions. They tie into the issue of conscience and the kind of Rawlsian position that you adopt. And I'll try to make this as quick as possible.

In your discussion of conscience you argue that the popular account of conscience, inner moral sense, et cetera, cannot accommodate inner conflicts of conscience. I think that's true only if you are approaching conscience from a strictly deontological point of view. It seems to me that within other alternative understandings of conscience, there is indeed the recognition that conflicts of conscience are going to occur, both within the individual, between the individual and what society mandates, and so forth.

If you look at the whole great tradition of casuistry that we heard something about this morning, the presupposition is that there are going to be some mandates of conscience, if you will, that may at times be overridden because other mandates of conscience trump at a particular point in time. So, again, it's the adoption of a particular moral philosophy that leads to that particular view about conscience and doesn't cover the whole at all.

On the issue of Prof. Rawls and the RLPRG — I have no idea how you would say that — RLPRG, something like that — the group of people that you freely choose. I certainly didn't freely choose Ms. McCarthy in the seventh grade, but she's in my head. I mean, the notion that you could simply at one point sort of say, "I choose you special five people. You're going to be my reference here," that could become entirely narcissistic.

You know what you would wind up with is a nice group of people validating you and some of that horrible language. And I want my parents out of it because they don't like the fact that I've chosen to be a happy-go-lucky beach bum. So, you know, I don't want them saying anything to me. I want other happy-go-lucky beach bums who are going to second my motion.

So I'm not sure that this is again a tremendously helpful way to think about especially moral formation, because most of our — and I'm sure you won't disagree with that. Most of moral formation takes place before we start picking who we want to be with in the world.

So I'm afraid these are more comments than questions, but I thought they might be worth putting on the table for your consideration. Thank you.

CHAIRMAN PELLEGRINO: Next is Peter Lawler.

PROF. LAWLER: Right. And thanks to you all for some wonderful presentations. They're very thought-provoking. I thought the most challenging thing Dr. Curlin talked about was this challenge to the distinction between personal ethics and professional ethics, which you are to assume, that personal ethics is somehow religious or comes from the group which affirms your rational life plan. And we have this. We have to take it seriously; nonetheless, it often conflicts with professional ethics, which is more objective, rooted more in health.

So you knock yourself out to not want to privilege professional ethics over personal ethics, but you still did finally, because one seems rather subjective and arbitrary — you know, who knows where this group comes from — and the other seems more real and scientific. Prof. Curlin said it. I just don't see that going on.

When I see conscientious objection, I see doctors giving reasons and they're giving reasons about health. When doctors conscientiously object to performing an abortion, because they don't see how abortion contributes to health. And the same with contraception and the same when they refuse to prescribe Prozac for ordinary unhappiness and so forth.

And so Robby's objection to abortion is not religious. It may conform with his religious belief, but he writes book after book showing how it's rooted in science, the facts about health. This is a matter of legitimate controversy. And Dr. Curlin had this great quote from Leon Kass where he says, "As medicine gets more powerful, we become more unclear about the ends of medicine because it becomes more unclear what health is," and when we enter the era of enhancement where we'll be able to satisfy people's desires and call that medicine, when we enter the era of biotechnology, it's going to become more and more unclear what health is.

So let's give our — Dr. Curlin gives our doctors more credit. They give reasons. Their objections are rooted in the legitimate controversy — to the legitimate scientific controversy over what health is. So

the more powerful medicine becomes, the more the domain of conscientious objection should be allowed to expand because the domain of reasonable controversy over what health is is going to expand. So I wonder if you diminish unreasonably these conscientious objectors by calling them merely religious or merely — you know, referring to whatever that initial group is.

PROF. BRODY: To whom was that question asked?

PROF. LAWLER: I wondered whether you now agreed totally that Dr. Curlin was right in his criticism of you on that.

PROF. BRODY: I will elect to respond, then, if I may. I disagree with Dr. Curlin in one way, and I would want to just add a qualification to what Dr. Curlin said in another way.

The way I disagree with Dr. Curlin is I believe Dr. Curlin has confused two very different concepts. He's confused conscientiousness with appeals to conscience. And there are many, many things in life that I could do conscientiously, and one thing I can do conscientiously is give you moral reasons in defense of my judgments.

That does not necessarily mean that I have appealed to conscience in the way I would define — or I take it Prof. Paris would define conscience. So I would want to have a very clear distinction between simple conscientiousness and an appeal to conscience. So that would be my main disagreement.

My qualification I would add to what Dr. Curlin said is that I understood the primary focus of the discussion and came essentially prepared to talk about, when a professional says, "I don't want to do something," and the main reason they give for not wanting to do it is, "It offends my personal conscience," which doesn't have to be religious, but may be religious.

Now, another reason you could give — which I agree is totally legitimate and should be investigated deeply — is, "I object to this because it's not professional. It's outside the bounds of the goals of medicine" or the goals of nursing or pharmacy or whatever. That's a perfectly legitimate line of argument. It deserves very careful scrutiny.

If I take the first line of argument, "It offends my personal conscience," I don't believe logically I'm saying anything that necessarily impacts on any other professional, except those who happen to come from the same philosophical, moral, perhaps religious tradition that I come from.

On the other hand, if I say it in terms of "This violates my professional integrity because it's outside the bounds of dealing with health, it's not a health issue," then I'm implying that no physician of integrity, no nurse of integrity, no pharmacist of integrity really ought to do that either. They're misguided if they think that they should be doing that.

So those are very different kinds of arguments and they deserve — each one could be a very serious argument and each one could be accompanied by a lot of reasons in addition to the appeal to conscience or the appeal to professional integrity, all of which would then need to be carefully sorted out. Some might be empirical claims; some might be moral claims. Most in one way or another, I agree, are going to be value laden, and we deserve to sort out the value laden features.

So had we wished to, we could have gone in that other direction. We could have said, "Let's look at what do you mean by professional integrity, what do we mean by the goals of medicine, the goals of pharmacy, et cetera." And those are heavily, heavily value laden ethical concepts — what is health. And we could have gone that way had we elected to do so.

CHAIRMAN PELLEGRINO: Dr. Curlin, did you want to comment?

DR. CURLIN: I think that what Prof. Brody is doing is defining an appeal to conscience, in my judgment, too narrowly as an appeal that will not give a further reason and then defining as conscientious reasoning those appeals that give a reason. And I guess I would say that certainly I would agree that a physician who says I am not going to provide this thing that other people think I should provide by virtue of being a physician or because of my position as a physician needs to give some account as to why they don't think being a physician implies providing that thing.

Again, in my understanding with respect to all these areas of controversy those reasons are given. Some people are not as articulate about it, but reasons are given. These are not arbitrary refusals.

And I think I do agree with Prof. Elshain that there's a lot that's hidden — and Prof. George — a lot that's hidden under the language of standard versus not standard or personal versus professional or private versus public or objective versus subjective or all that language — are hidden in this debate

about what, in fact, we're obligated to do as physicians.

And my last thought on that would be just that medicine would not be a profession of such prestige historically if people were having to — if the profession we make implied putting aside things that we think are very good, but rather the reason it's been seen as a noble profession as it's always been understood as a professing upward — in effect, taking on new commitments that are higher, not lower than the ones you had before.

And so the notion that you have a professional integrity and a personal integrity seems to me wrong-headed in the sense that of course you have commitments that are specific to your professional role and those that are not, but having integrity is to know how to act in light of both of those, it seems to me, not to give up one form of integrity for another.

CHAIRMAN PELLEGRINO: I have a problem. We have lots of commentators and questions, so we may at some point ask you to just hold it, and then when you have an opportunity, get it. Prof. Gómez-Lobo .

PROF. GÓMEZ-LOBO: Thank you. I want to go back to the very notion of conscience that underlies part of our discussion. And the reason why I do this — and I'm addressing this to Prof. Brody — is because of that claim that certain dictates of conscience ought to lead certain individuals not to choose a health career. I was really worried about that, not because I'm about to embark on a health career — it's too late in life for that — but I think that there's a deep misunderstanding there.

And let me start with the ACOG committee opinion where conscience is — first it says it expresses a sentiment, such as, "If I were to do X, I could not live with myself, I would hate myself, I wouldn't be able to sleep at night," and then the opinion piece goes on to say "according to this definition."

Now, I find that incredible. I mean, it's such a misunderstanding of what's going on. It may be a consequence of that conscience that I cannot sleep at night, but conscience is a particular practical judgment as to whether what I'm going to do is morally right or morally wrong, which means whether I'm going to harm a human good or benefit a human good.

And in that regard I totally agree with Dr. Curlin . It is in a very important sense a public judgment. I have to give reasons. I cannot just say my conscience tells me to do this. I have to go on and give reasons.

And in that regard, for instance, it seems to be absolutely natural and even a duty of a doctor who refuses to perform abortions to say why he or she refuses to perform an abortion. I mean, that has to be clear and up front. It's a human good that is going to be harmed.

Now, if we view it in this way, then there's no conflict between integrity of the physician or the care giver and the benefit of the patient. On the contrary, the judgment of conscience is a judgment about the good of the patient. It's not a judgment about my integrity. It's a judgment about what objectively I would be doing if I did it and that's why it is such a crucial thing.

Now, I would want to add this on the balancing question. There's a very serious problem there for the following reason. It ultimately seems to me judgments of conscience can be modified. In other words, I can be led to change my judgment of conscience. For instance, if there's empirical evidence about emergency contraception, for instance. That's seems to me absolutely natural. Again, that shows that judgments of conscience are public in a very important way.

But once I have all of the available evidence, once I have decided that it be wrong for me to do it, I have no further way of judging the truth of my — of passing judgment on the truth of my conscience. Now, what does that entail? It entails that there are no occasions in which it would be rational to force someone to act against their conscience because that person would always be doing something morally wrong if she would act against her conscience. So integrity is a derivative of acting in accordance with one's conscience, but conscience itself stands in a quite different position with regard to the patient and with regard to health and the basics of the medical profession.

So I would plead with Prof. Brody , please don't exclude from a medical or a health career someone who thinks along those lines. On the contrary. Thank you.

PROF. BRODY: Yes. If I thought that by saying that there might come a time when one would be forced to suggest to a person of conscience that because you're a person of conscience you ought not to seek a career in health care — I would be horrified if that was a common sort of thing.

However, I gave one example, which I think typifies the sort of very extreme case I had in mind

where that might come up and that was the example of the Jehovah's Witness anesthesia resident who would not give a blood transfusion to a non-Jehovah's Witness patient even if the consequence might be the death of the patient.

Now, I believe that someone — I can't remember where I read this — but someone gave the example of would a Quaker, for example, or a pacifist seek a commission to West Point . At some point, practically speaking, there's such a conflict between what you feel required to do as a matter of conscientious commitment and what you know is a role responsibility normally expected of people who undertake that kind of career that there's a serious question of practical wisdom or prudence of saying that's the field of work I want to go into. So that was the kind of extreme case, exceptional case, that I had in mind.

I also thank you for highlighting the question about how your conscience could be wrong and you'd want to give reasons and why it's a public act of giving reasons to correct the conscience if the conscience is mistaken because I think I just heard a minute ago Dr. Curlin say that I said that when you appeal to personal conscience, then you don't have to give any reasons. So I hope I didn't say that.

I certainly did not intend to say that, and I hope that by saying conscience can be corrected and could be wrong, I specifically made that point, that, yes, you could be called upon to give reasons. And often giving reasons is a part of the exercise of conscience.

CHAIRMAN PELLEGRINO: Paul McHugh .

PROF. MCHUGH: I also join in the chorus of thanks to all of you for your thoughtful presentations, and my comments are really comments that come in part out of ignorance of the philosophy, but out of a lot of experience dealing with patients who say they have needs. I'm very worried about "needs" when a patient comes in and tells me that and so therefore I was a little concerned about this little diagram that overlapped conscience with patients' needs.

Most patients' needs turn out to be wants, wishes, and sometimes fantasies, and our job is to sort them out. But where I come to want to ask a question and relate to what's been said, Dr. Brody , it begins with you, this very helpful distinction that you are making between what were private commitments and publicly made commitments, and particularly in oaths. You made that point.

I took an oath. I took the old Hippocratic Oath, the plain old straightforward, no abortions, no physician suicide, the old, hard line things like that and stick to to this day. And the point that you were making in drawing that sharp point I thought — and I might be wrong about this — is that you said that usually the public commitments were related to a public — to a given public stance where, at least in our society, things were settled on those public issues.

And I want to remind you that you could make a public statement like the public Hippocratic Oath and be at war with what the public stance became. And I want to remind you — I might make reference to three books that have been written in the last five years on each one of these matters that proved how often the physician publicly committing himself to the views of the Hippocratic Oath that was both private and public in that sense — you get up, say it, and do it — proved that they had that public commitment, really meant something that was driven by his real private sense.

And the three books — one was the book by Kevles on eugenics, where 35 states in the union sterilized people because they thought they were mentally retarded. And many of those people were not, and many of them weren't even told that they were going to be sterilized and were distressed to learn later in life that their failure to conceive had been done to them. Okay, and that's the first one. [Daniel Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Cambridge, Mass: Harvard Univ. Press, 1998).]

The second arena that has just been recently was a book by a historian at Columbia — H. Scanlan , I think. The title of the book, the fascinating title of the book, is *Fatal Misconception*. It's a marvelous book on the imperialism of American contraception imposed upon the people of India and China and other places of this sort where what ultimately has come — because we had no — we were so committed to our view on population and had no reason to — we're not going to be held responsible are now held responsible for having done things like enforced sterilization amongst those people. [Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population*, Harvard University Press, 2008.]

And then the final book written only a year or so ago is Helen Epstein's book entitled *The Invisible Cure* [NY: Picador, 2008] where our medical services going into Africa to try to help in HIV totally refused to listen — thinking in mechanical terms refused to listen to the women of Uganda who had

demonstrated unquestionably that the partner reduction approach was the correct approach to the ending of it, whereas, we, running our zeal for the condom method, continued to have a huge a death rate for HIV in young women in other African countries.

Again, you made a point that you — this might not have been where you were going to come in, but I want to ask you that question, why you would think that a public commitment that was voiced in terms of care of patients might not sometimes run against the public stance on matters related to services to people.

PROF. BRODY: Thank you for the challenging question, because I think you've — frankly, I think you've wrapped up a number of very, very important issues, and I am going to have a very hard time disentangling them in order to be able to say anything at all wise.

Let me be very simplistic in responding to just one point, which is what is the big deal about the public promise. And what I'm saying is when physicians get up together and say the oath — and what I meant by that was less the content of the oath, but the idea of we all get up and say the oath — is the ability of the public then to trust physicians to have made some kind of promise to them for which we are accountable.

And my willingness — if I am hit by a car on the way across the street to get back to the Metro and I am whisked to an ER here in Washington and I don't know the doctors, I don't know the nurses, on what basis am I going to trust that they will be looking out for my health.

And a very important piece of the reason I'm going to trust them and I'm going to not demand that I see their biographies and did they really get their diploma, et cetera, et cetera, is because I imagine they have engaged collectively in this commitment to the well-being of the patient, that I'm now a patient and I'm going to take advantage of their commitment to my well-being.

So it's really that ability of the public to respond to this public act with the bestowal of trust. And to have that trust be merited, not just, you know, a mistaken trust on the part of the public, but a merited trust in us because we've taken this commitment is what I frankly — was at the root of this appeal to the public.

Now, then, I would just simply add to that — if I go back to my example of should a pacifist seek a commission at West Point, I would imagine that there are folks at West Point who believe, for example, that American military policy today is very misguided and that if they ever were to rise up far enough into the — there may be only a few of them, but if they were ever to rise up high enough in the hierarchy, they would do what they could to change that policy.

And it is good and it shows that we are a vigorous and lively profession if there's this active dissent in our ranks about what do we mean by our commitments, what did we promise the public, what is health. These are all questions that are potentially contested, these are all questions on which some scientific facts are pertinent and moral values are pertinent and social policy is pertinent. As you point out, international relations are even pertinent. And so we should be having a vigorous debate about this

And so whatever I get up and promise the public that I'm going to do — I may have my personal doubts about it. I may carry out internally a dissent within medicine about it, but I have to be careful of when I treat my patients to be sure that I don't confuse my personal take on this contentious issue with the larger commitment made by the whole profession.

So there are some things where we can have a lot — it just so happens that we have a lot of agreement within the profession about what we ought to do, and there are other instances where there's a lot of disagreement about what we ought to do, and I at least ought to be clear on that.

I ought not imagine that if I'm a minority of just a very small number of physicians who believe something that I speak on behalf of all of medicine when I get up and say that thing. That's what I think we need to guard against.

CHAIRMAN PELLEGRINO: I have five members of the Council who wish to comment, and we're checking on seeing whether we need to evacuate this room at 5:00 . I don't know. We'll be finding out shortly. So Dr. Carson .

PROF. CARSON: Just a short comment with perhaps a short rhetorical question associated with it. First of all, I thank the three of you very much. I think most of what was said has general applicability to the medical profession and is very wise; however, when it comes to what I call 50/50 issues, things like euthanasia and abortion where you have very substantial portions of the

population that have varying opinions, I wonder if maybe our energies could be better spent looking for ways to be able to accommodate everybody.

I sometimes feel on these kind of discussions that we're in Congress, you know. You can't get anything done. It's my way or the highway. And, in fact, even going to an extreme example, such as the Jehovah's Witness — and, you know, obviously as a surgeon, I give plenty of blood, but let's say someone was a Jehovah's Witness anesthesiologist — you know, I run into a lot of Jehovah's Witness patients who don't want any blood. Maybe we compare those people — the point being that perhaps if we spent a little extra time figuring out ways to accommodate as opposed to exclude, we could get further along in this argument.

CHAIRMAN PELLEGRINO: Next I have Dr. Hurlbut .

DR. HURLBUT: I want to continue in the line of discussion that Alfonso and Paul have initiated and I wanted to ask Dr. Lyerly, is it impossible to put the slide with the quote from Julian Savulescu back up?

DR. LYERLY: I don't know.

DR. HURLBUT: As you try to do that, let me go to where I want to go here. What I want to try to get at here is — first of all, I want to ask you a question and then I want to make a comment on it, depending on what you say, of course. But I want to get at the challenging dimensions of what we're actually doing here, because it's easy to focus on a single issue like abortion or sterilization and miss the larger context of the drift of medicine across time and culture and so forth, and we need to seek a very broad foundation for the future of medicine.

And so I want to just specifically ask you, Dr. Lyerly, in your report what principle of professional obligation did you — where did you draw — more specifically I'm a little troubled by what's already been brought out — the emphasis on conscience being sort of a personally driven thing, and then just a page later you say, "By virtue of entering the profession of medicine, physicians accept a set of moral values and duties that are central to medical practice." And where do you see those as coming from, I guess is the chief question.

DR. LYERLY: I'm not at liberty to comment on 385.

DR. HURLBUT: Okay, your own opinion, then, on those issues.

DR. LYERLY: I mean, I've been asked not to comment or — I've been asked not to comment on the document, and so I really can't do that. I'm sorry.

DR. HURLBUT: Okay, let's forget about the document. Let's go back. We're talking more broadly about the very crucial issue that Dr. Curlin has raised about professional obligation, and I think he's zeroed in on the key question here. What are the professional obligations? They're clearly not just individually decided on from somewhere or nowhere. What would be our sources for this — for understanding these parameters?

DR. LYERLY: How might we understand the professional obligations of doctors and other health professionals?

DR. HURLBUT: Right. Where do we go?

DR. LYERLY: I mean, I think that's a wonderful question for this group to start thinking about. I mean, what I would add and what I tried to reinforce today is that conversations about health and the aims of health need to engage the perspective of the people who will be benefited or be harmed by its provision.

So it is not just the providers of health care or even theorists about health and its meaning that should be at the table, but it needs to be people that live in these bodies, experience the impact or not of conditions, technologies, living in the world, living in cultures, and we need to incorporate those views as we think forward about what the aims of health are.

DR. HURLBUT: In other words, the good of the patient. I mean, that's what you're saying?

DR. LYERLY: Right. I think that's part of it, but what — for us to understand what health is and what the goals of medicine are, we need to hear how people experience what we do. So that's an important part of the equation that I don't think has been there.

I think in the last ten, fifteen years we've been much better at gathering data about that. We've

gathered beautiful empirical data about how people experience end-of-life care and it's transformed the way that we provide it. We're beginning to collect data to listen to people about how they experience care during the process of birth, and I expect that that is also going to change the way that we think about pain in labor, support, et cetera.

So in crafting what we think is good health care, we cannot do so and we can't think about whether it meets ethical standards unless we listen, unless we take a moment to listen. So I just — I would urge the brilliant people who are deliberating about this to consider the views of people who experience patient —

DR. HURLBUT: Is the quote possible to show or no?

PROF. ROWLEY: Come on, now.

DR. HURLBUT: Can you read it?

PROF. GOMEZ-LOBO: "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."

DR. HURLBUT: So, look, I can certainly agree with you about listening to the patient, but it seems to me there are other things we have to listen to and not — and these are very serious issues, because we want to transcend time and we want to transcend culture as we deliberate on these issues.

And the quote that was read seems to — there's something wrong in it, and I can feel it. It's excluding people from the dialogue by saying, "If you don't like it, don't go into this profession." And so what I'd just like to briefly lay out is a couple of parameters that have not been mentioned.

It seems to me that the examples that are given in the paper — sterilization, artificial insemination for a lesbian — one might add issues you didn't bring up like face lifts or growth hormone. How do we decide these kind of issues?

Now, quite apart from whether or not they should be legal or not, there ought to be some reference to — in grounding medicine to the natural standards of health and the immanent powers of the body. And I can't see that some of the issues that you've raised as sort of moral controversies qualify as that.

I mean, whether or not it should be legal for a lesbian to be inseminated is quite different from the question of whether a physician should feel like that's part of his profession obligation. It doesn't seem to me that that's part of the natural immanent powers of the body to be inseminated without the act of sexual intercourse.

Now, maybe I'm wrong. Maybe you could make an argument for that, but it seems to me that by saying in the text that you supplied that she was prompted — this physician was prompted by religious beliefs and some disapproval of lesbians having children — I mean, that doesn't seem to me necessary to label that a religious belief. There's an attitude there that might say, "Well, that's not a natural phenomenon that I'm trying to heal." Do you see what I'm saying?

DR. LYERLY: Again, I'm not at liberty to comment on the paper, but I will say it sounds like you are making an important contribution to thinking about how we're going to define health. And there is a claim that it has to do with — I don't want to misquote here, but having to do with the body's natural functioning. Is that correct?

DR. HURLBUT: Some reference to natural functioning, yes.

DR. LYERLY: So I think an argument can be made for that, certainly, but I don't think that we can take that as truth anymore than any of the other considerations on the table without a moral argument for it. So I think that would be an important thing to think about, but I don't think we need to presume it is or it's not at this point.

DR. HURLBUT: But just to make a brief conclusion of this, it seems to me that — I mean, we're talking about an issue — say just the abortion issue alone. There's an enormous history on this issue. I mean, here just for example from the physician's oath in the declaration of Geneva in 1948, "I will maintain the utmost respect for human life from the time of conception, even under threat."

I mean, this is very different from the prevailing sentiment that's going on right now, and there seems to be a sort of social pressure that's being imposed on the medical profession as a whole to accept this kind of realm of things as though it has no past. And it seems to me if we're going to enter a profession, as your document says, with moral beliefs and values that echo our profession, we

should look more seriously at history.

We've got a very challenging era ahead with biomedical technology. It's knocking us off balance. The new paradigm for medicine seems to be liberation, not a reference to what would be called restoration or healing of the body. This is going to challenge us very deeply, and if we don't have any grounding in this, if we simply say, "If you don't like it, don't join the profession," that seems to me setting us up for some big problems. It's like closing the conversation rather than opening it.

And just to emphasize this, before we had the session I went back — and admittedly this is heavy-weighted and maybe disproportionate — but I went back and I read a couple of papers on medicine under the Nazi dictatorship, and, boy, they're powerful things. I mean, it's hard to believe that some of us in this room were alive when this was going on.

And just to give you two brief quotes, it says, "The chief of the medical institution Hjalmar was responsible for the murder of over a thousand patients. He personally opened the containers of gas and watched through the peephole the death agonies of the patients, including the children."

And then at the Nuremberg trials he stated, "I was of course torn this way and that. It reassured me to learn what eminent scientists partook in the action." And then Leo Alexander, who wrote part of the Nuremberg Code, warned us. He said, "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude basic in the euthanasia movement that there is such a thing as a life not worth living."

Just to conclude, let me point out that the guy whose quote you used, Julian Savulescu, who would like to say some people shouldn't join the profession if they just can't get along with the standards, has himself advocated the creation, gestation, and harvesting of cloned human embryos. And this is a quote. He says, "Indeed it is not merely morally permissible, but morally required that we employ cloning to produce embryos or fetuses for the sake of providing cells, tissues, and even organs for therapy followed by abortion of the embryo or fetus."

I think the last thing we need right now is to be telling people that they shouldn't go into medicine. If anything right now, we need some diversity of views and to take this issue of conscience very seriously.

DR. LYERLY: I absolutely agree with you. I think it's wonderful that this committee is taking on this issue. I spoke to one of the committee members earlier and I — in addition to recognizing how important this issue is, I actually think it's a place where there's a potential for good, valuable, deeply rich deliberation.

I was asked by Dr. Pellegrino and Dr. Davis to demonstrate a range of views that's out there right now. They fall on a spectrum. I was asked not to advocate for a single position, but to demonstrate a range of views. I used Savulescu's quote word for word because I think it does show a view on one end of the spectrum, which is a very — a view that is very impermissive of conscientious refusals, which I agree with you are — the role of conscience has a critically important place in medicine and bioethics.

So as we think forward, I think that dialogue is absolutely important. I think to engage in that dialogue with respect for people that don't hold the same views as you that bring to the table different conceptions of health, that bring to the table different ideas of what matters in how we should set professional standards, how we should treat our patients and the like — I think that conversation is absolutely vital.

Its tenor goes up several notches when we're talking about elective abortion, but it's important to a range of issues that arise in medicine. So I think — just in closing I think — I agree with you this is an important conversation. It's not going to serve anyone to shut people down on either edge, but in order to understand that there's a range of views — I mean, it's helpful to look at the edges.

And there has been some conversation today that we weren't contextualizing conversation, but that was partly what I was attempting to do with my introductory remarks. And I think we all come to the table with certain moral views, some of which we are wearing on our sleeve and some of which are very deeply held and we may not recognize it as starkly. So that being said, I appreciate your view and I think that thoughtful deliberation on this is exactly what we should be doing.

CHAIRMAN PELLEGRINO: I'm going to use the chairman's prerogative. We have three more members of the Council who would like to speak. We'll give them an opportunity to make their

comments and then afford the opportunity of a response on the part of our panelists. I have Dr. Rowley , Dr. Dresser , and Dr. Landry in that order.

DR. ROWLEY: Mine is going to be very short, and it was just somewhat similar to a concern of Dr. Brody's that Dr. Curlin seems to me to have — in his early examples, they were people who — physicians who disagreed with one another on various aspects of the appropriate medical care, and I think that's very different than the matters of conscience that we are discussing in this particular session. And those I would have classified as more differences amongst clinical judgment. And I think that they have to be separated out from matters of conscience.

CHAIRMAN PELLEGRINO: Thank you, Janet . Dr. Dresser .

PROF. DRESSER: Well, we have this pluralistic country and practice of medicine and it's also organic in that it's changing and we — and I'm sure in a hundred years we'll look back on things we approved of today and shake our — people will shake their heads, so on and so forth.

So I guess I would like to second Ben 's statement about — to talk about accommodation, more about what institutions, professional organizations, medical schools, and so forth can do in terms of procedures, systemic approaches to allow people who have objections of conscience to act accordingly and at the same time to meet the standard of care.

I agreed with Howard Brody 's comment about how many of these can be settled within institutions. You just have to plan. People who come in who have objections need to — have a duty to state them and others need to be aware and there needs to be arrangements made. Perhaps in some cases it's not possible, for example the Jehovah's Witness, but it seems to me it's easy to get very polarized and rigid and say, "Oh, patients need them, personal conscience and so forth," but this is a social/professional problem, as well.

And so it's perhaps not as interesting to talk about things like scheduling and so forth, but it seems to me that's where a lot of this will live out and you can minimize the damage on both sides by working on that stuff.

CHAIRMAN PELLEGRINO: Thank you, Rebecca . And Dr. Landry .

PROF. LANDRY: I'd just like to say thank you to the panelists, and just some quick comments about conclusions. Dr. Brody , in yours you look at mild versus strong interpretations, and perhaps that's a way. There's wiggle room to sort of get by. And the idea is that willingness to refer will be mild and unwillingness will be strong.

But then there was an aside about rural areas, and I got the feeling that if you're in a rural area and there was no one else to do it, then willingness to refer might end up being strong because to be mild you really have to perform it. And so maybe these aren't such absolute categories. They're sort of relative.

And the bottom line is you can object to the extent to which it doesn't have an effect. If it doesn't effect, then you're in sort of the other category. If you don't regard that as entirely fair, you can comment.

And, Dr. Curlin , you made an appeal that physicians who have their range of conscientious objection narrowed would be reduced to technicians, but isn't it more likely that they'll just be driven out. Some specialties will soon become hostile work environments and you'll get sort of the equivalent of ethnic cleansing. It will be sort of a ethics cleansing, and you'll get to the homogeneous view with potential on the other side.

I mean, I think a 38-year-old woman in New York or LA who becomes pregnant actually gets a lot of pressure for amniocentesis, and with a Down's diagnosis a lot of pressure for abortion, which would then harken to the issue of this being simply a matter of politics and political views and not really a science driven enterprise. So those are my comments.

CHAIRMAN PELLEGRINO: Thank you very much. Now we'll give an opportunity for each of the panelists to make what comment they would like to make. I'll start with Dr. Curlin .

DR. CURLIN: If I can begin with the last comment, I think that they would be both driven out as well driven being technicians in this sense. And I don't want to make it overdramatic. At this stage most people of a wide range of moral views can effectively practice and are not being driven out, although there seems like there's a growing sense of a threat.

But they would be, of course, driven out if they were required to do things that they could not in good conscience do. They would have to, to live with understanding and live with integrity, leave the profession.

But they would also, I think — the profession is driven toward a provider/consumer model because the impulse that leads — and it comes out in all these essays — that leads to the judgment that we should constrain conscientious refusals is something on the order of "Doctors have no business making judgments about whether that thing is good for patients or they don't have the authority to make that judgment, or if they do make that judgment, that's a threat."

And so to the extent doctors retreat from — and Prof. Brody in that essay about , I don't need — if I'm misinterpreting how it would apply to this situation, I'll let him to speak that, but it said that what you don't want is doctors retreating from making recommendations, retreating from seeing themselves as responsible for your good, responsible for your health. And to the extent you say, well, you're responsible so long as you are willing to do these things that you think are not ethical, then I think that drives in that direction.

And with respect to Prof. Rowley 's comment, I do think there is a difference between disagreements that you described as clinical judgment. You said some are clinical judgments versus appeals to the conscience. They are different, but the difference is in some cases you have an agreement about what the ends of medicine are, about what we're after here, and a disagreement about how best to pursue it.

The difference is not that one is conscientious and one is not. The difference is that some are disagreements about what the ends of medicine are and some are disagreements about how to achieve those ends. And then within the former — about what the ends of medicine are — sometimes these disagreements track onto religious teachings and some don't.

And it seems to me that in our culture, because of these rubrics of private versus public and whatnot, those that can be seen as tracking more directly onto religious disagreements are seen in a kind of prima facie way and I think in an incorrect way as being less valid to be considered in one's making decisions about one's practice.

CHAIRMAN PELLEGRINO: Dr. Brody .

PROF. BRODY: Specifically in response to Dr. Lawler's comment, which was quite helpful, I would ask you that if you wish to consider what I said to see whether it's of some value for your deliberations here, please keep in mind the title "Two promises."

The reason I say that is because — if I may give an analogy — it may be a very, very imperfect analogy — I believe today I made two promises. I made an implicit promise to my wife that if our home were to be threatened, I would be at her side and would not go running away to some academic thing that would take me away from my home responsibilities, and I made a promise to the President's Council on Bioethics to be here at this hearing.

Whether I'm able to keep both promises has a lot to do with how fast a certain hurricane is moving across the Gulf of Mexico and which direction it's going. I may find tonight that I was able to get home in plenty of time and do what I need to do and all will be well. I may discover that I was too late and I'm trapped in Washington and she's trapped in who knows where. And a lot of practical things will get in the way of whether I'm able to keep both promises or whether I find that my commitment to one promise interfered with my ability to keep the other promise.

So it may seem cute or sort of begging the question if I said, well, the rural circumstances may be different, but sadly, I think, if you look at it from the point of view of these are two promises — and I believe — the reason I said two promises is because I happen to share the concern people have with the idea of balance.

I wanted to avoid the idea that we're trying to balance something, and so I was looking for another way to say that, that I hoped would be more enlightening. And I chose the two promises, and maybe it worked, maybe it didn't, but I think your comment gets right to the heart of what might be of value or might not be of value in making that analogy of the two promises.

And just to complete, since we are looking back at slides, I would like to read my last slide, because I believe it very much fits with what Dr. Dresser said and what Dr. Carson said. My last slide was titled "Personal Hope."

"In the future we will see more examples of conscientious objection dealt with by local

accommodation in the spirit of mutual respect and few instances of the use of political or financial power to favor only one promise."

CHAIRMAN PELLEGRINO: Thank you, Howard . Dr. Lyerly .

DR. LYERLY: Well, that would have been a beautiful way to end on hope, but I just want to take a minute to address a worry that seems to have surfaced today, which I find interesting and not one that had struck me particularly, and I wonder if it's just the way that we think about things, namely that limitations or potential accommodation of providers' rights of conscientious refusal necessarily are going to translate into a provider/patient relationship in which one is the technician and one is the consumer of goods.

I think what the concern is on the side, too, of individuals that are worried about the expression of conscience is also silence in that relationship between doctor and patient, that not talking about options, not exploring the ways in which those options might have meaning for somebody, but instead refusing to talk about things and refusing to make sure that the patient's needs — and I don't consider the patient's needs frivolous. I consider them deep and concerning and oftentimes not intuitive — you know, how to make sure that those things are met.

And so in some ways it may have to do with the idea of what sorts of things a conversation can do. So if we're only talking about conversations being an exchange of information or the provision of — or attempts to persuade people to do one thing or another, then I can see where that concern comes from. But conversations do a lot more.

Conversations between patients and their physicians establish trust, they help shape options for people, they make people feel cared for, and my sense is that that is and continues to be a goal for people who are concerned both about maintaining providers' rights to conscience and also about individuals who are concerned about the impact of expression of conscience on patients' well-being.

CHAIRMAN PELLEGRINO: Thank you very much. You three panelists really put on a heavy afternoon, and we really appreciate it. Thank you.

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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.

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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



Rebecca Dresser, J.D., M.S. Daniel Noyes Kirby Professor of Law, Washington University School of Law, and Professor of Ethics in Medicine, Washington University School of Medicine. Professor Dresser has written extensively on bioethical issues, and she serves on the editorial board of *IRB: Ethics and Human Research*. Her book, *When Science Offers Salvation: Patient Advocacy and Research Ethics*, was published in 2001. She is also a co-author of *The Human Use of Animals: Case Studies in Ethical Choice* (1998) and *Law and Bioethics: Cases, Materials and Problems* (2003).

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JEAN BETHKE ELSHTAIN, PH.D.

COUNCIL MEMBER



Jean Elshtain is a political philosopher whose task has been to show the connections between our political and ethical convictions. Her books include *Public Man, Private Woman: Women in Social Thought*; *The Family in Political Thought*; *Meditations on Modern Political Thought*; *Women and War*; *Democracy on Trial* (a *New York Times* "Notable Book" for 1995); *Augustine and the Limits of Politics*; *Real Politics: At the Center of Everyday Life*; *New Wine in Old Bottles: Politics and Ethical Discourse*; and *Who Are We? Critical Reflections, Hopeful Possibilities*, for which she received the Theologos Award for Best Academic Book 2000 by the Association of Theological Booksellers. In 2002, she published a book, *Jane Addams and the Dream of American Democracy*, and an edited volume, *The Jane Addams Reader*, which won second place for biography in 2002 from the Society of Midland Authors. In 2003, she published *Just War Against Terror: The Burden of American Power in a Violent World*, which was named one of the best non-fiction books of 2003 by *Publishers Weekly*. In addition to her book-length studies, Professor Elshtain writes widely for journals of civic opinion, and lectures, both in the United States and abroad, on whether democracy will prove sufficiently robust and resilient to survive. She is a fellow of the American Academy of Arts and Sciences and chair of the Council on Civil Society. She has served on the Board of Trustees of the Institute for Advanced Study at Princeton University and is currently on the Board of Trustees of the National Humanities Center and on the Board of Directors of the National Endowment for Democracy. She has been a Phi Beta Kappa lecturer, is the recipient of nine honorary degrees, and received the 2002 Frank J. Goodnow Award, the American Political Science Association's highest award for distinguished service to the profession. In 2003, Professor Elshtain was the second holder of the Maguire Chair in Ethics at the Library of Congress.

In 2006, she was appointed by President George W. Bush to the Council of the National Endowment for the Humanities, and also delivered the prestigious Gifford Lectures at the University of Edinburgh, joining such previous Gifford Lecturers as William James, Hannah Arendt, Karl Barth, and Reinhold Niebuhr. The lectures are forthcoming under the title *Sovereignities: God, State, and Self* (2008).

Professor Elshtain also currently serves as co-chair of the Pew Forum on Religion and Public Life; and chair of the Council on Families in America. She was chair of the Council on Civil Society; and a member of the National Commission for Civic Renewal and the Penn Commission on American Culture and Society (1996-1999). She was a Phi Beta Kappa Scholar for 1997-1998. She served as vice-president of the American Political Science Association for the 1998-99 academic year. She is a member of the Board of the Illinois Humanities Council.

Jean Bethke Elshtain is married and the mother of four children: Sheri, Heidi, Jenny, and Eric -- and the grandmother of three: JoAnn Paulette Welch and Christopher Matthew Welch; and Robert Paul Bethke.

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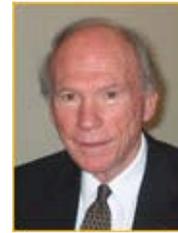




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DANIEL FOSTER, M.D.

COUNCIL MEMBER



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.

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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.

He is the author of *Making Men Moral: Civil Liberties and Public Morality* (1993) and *In Defense of Natural Law* (1999), and editor of *Natural Law Theory: Contemporary Essays* (1992), *The Autonomy of Law: Essays on Legal Positivism* (1996), and *Natural Law, Liberalism, and Morality* (1996), all published by Oxford University Press. He is also editor of *Great Cases in Constitutional Law* (2000) and co-editor of *Constitutional Politics: Essays on Constitution Making, Maintenance, and Change* (2001), from Princeton University Press, and *The Clash of Orthodoxies* (2002), published by ISI Books. He is co-author of *Embryo: A Defense of Human Life* (2008, Doubleday) and *Body-Self Dualism in Contemporary Ethics and Politics* (2008, Cambridge University Press).

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.

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**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.

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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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DONALD W. LANDRY, M.D., PH.D.

COUNCIL MEMBER



Donald W. Landry, M.D., Ph.D., is Professor of Medicine, Director of the Division of Experimental Therapeutics, and Chair of the Department of Medicine at Columbia University. Dr. Landry completed his Ph.D. in Organic Chemistry under R.B. Woodward at Harvard University in 1979 and obtained the M.D. degree from Columbia University in 1983. After completing Residency in Internal Medicine at the Massachusetts General Hospital, he returned to Columbia to join the faculty of Medicine. His basic research program focuses on drug discovery and artificial enzyme approaches to intractable drug targets, e.g., cocaine addiction. His clinical research and clinical practice centers on his discovery in critical care medicine that vasopressin insufficiency contributes to vasodilatory shock and can be treated by vasopressin infusion. He and Columbia colleague Howard Zucker pioneered the alternative, embryo-sparing approach for the production of human embryonic stem cells based on the harvesting of live cells from dead embryos by extension of the established ethics for the harvesting of essential organs from deceased donors.

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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.

Lawler has published more than 125 scholarly articles, chapters, and reviews. His writings have appeared in such scholarly journals as the *Review of Politics*, *Government and Opposition*, *The South Atlantic Quarterly*, *The International Philosophical Quarterly*, *American Political Science Review*, *Journal of Politics*, *Gravitas*, *Interpretation: A Journal of Political Philosophy*, *Polity*, *Modern Age*, *Public Integrity*, *The Intercollegiate Review*, *Presidential Studies Quarterly*, *The Public Interest*, *Perspectives on Political Science*, *First Things*, *The Good Society*, *The New Atlantis*, and *Society*. He is also published in more popular magazines such as *The Weekly Standard*, *Current*, *The Claremont Review of Books*, *The University Bookman*, *The American Enterprise*, *Crisis*, *The National Review*, and *National Review Online*.

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, conservationism, 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.

Dr. Lawler recently edited a book on Tocqueville and American political life today and the fifth edition of *American Political Rhetoric*. He wrote an introduction to the new Sheed and Ward edition of John Courtney Murray's *We Hold These Truths*, and book chapters on religion and the American founding, Locke and American greatness, Flannery O'Connor, and *Casablanca*.

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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.

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GILBERT MEILAENDER, PH.D.

COUNCIL MEMBER



Gilbert Meilaender, Ph.D. Richard & Phyllis Duesenberg Professor of Christian Ethics at Valparaiso University. Professor Meilaender is an associate editor for the *Journal of Religious Ethics*. He has taken a special interest in bioethics and is a Fellow of the Hastings Center. His books include *Bioethics: A Primer for Christians* (1996, 2005), *Body, Soul, and Bioethics* (1995). He has recently edited (together with William Werpehowski) *The Oxford Handbook of Theological Ethics*.

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JANET D. ROWLEY, M.D., D.Sc.



COUNCIL MEMBER

Janet D. Rowley, M.D., D.Sc. Blum-Riese Distinguished Service Professor of Medicine, Molecular Genetics and Cell Biology, and Human Genetics, Pritzker School of Medicine, University of Chicago. Dr. Rowley is internationally renowned for her studies of chromosome abnormalities in human leukemia and lymphoma. She is the recipient of the National Medal of Science (1999) and the Albert Lasker Clinical Medicine Research Prize (1998), the most distinguished American honor for clinical medical research.

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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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