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Meeting Transcript

September 6, 2007

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SESSION 1: THE DRAFT WHITE PAPER ON THE DETERMINATION OF DEATH

CHAIRMAN PELLEGRINO: Good morning. Good morning. Welcome to the meeting of the President's Council .

The first act in these meetings always is for the chairman to recognize the presence of the official government representative who sits to my left, Dr. Daniel Davis, who is the Executive Director of the Council . Dan, we acknowledge your presence and are delighted to have you as always. Dan is the man who does all the work on the Council . You must know that. It's not just a title that he carries.

I would like to begin this Council meeting by expressing on my behalf and on behalf of the members of the Council our gratitude to Dr. Leon Kass who has completed his current course of appointment and has asked to resign from the Council .

It's my great pleasure to personally enter into the record, I hope adequately, the gratitude of the members of this Council to Leon, who really is the founder of the Council , the first chairman, its inspiration, and a person who has set a very high standard for the work of the Council and whom I've had the pleasure of knowing as a colleague for many, many years. Leon, we thank you most sincerely.

Leon is serving on the Council beyond his previous termination of term at my request, and I had hoped that he would continue. But his own personal preference is now to direct his attention to many, many of the other things which he's doing. We understand that.

But he has promised me to be available to us. And those of you who know him, know him as a source of wisdom that we did not want to lose any contact with, both personally and also, of course, officially as the Chairman of the Council .

So, Leon, thank you most sincerely. And if I can break precedent, I'd like to.

(Applause.)

This is one time, Leon, you don't have to respond. I'm sure Leon suspects, "Oh, there he goes," and he doesn't want us to say too much - not the case.

Our agenda this morning, or today rather, covers the following two topics: The determination of death, which has come to be a very actively discussed issue now that had been closed for many years or assumed to be closed; and then the latter part of the day some discussions of the status and the question of professionalism in medicine and the other health professions and, to a more distant degree, those other professions outside of the health field. Tomorrow, we will look once again and be brought up-to-date on the status of nanotechnology and the ethics associated with it.

I would like to begin the first presentation. Diana Schaub, a member of the Council , who will initiate an open discussion, has kindly consented to do so on the staff paper prepared by Alan Rubenstein. Dr. Schaub?

PROF. SCHAUB: As some of you know, I'm a fan of the original Star Trek series, and I remain unabashedly a fan despite the teasing that such a declaration can bring.

The best known line from Star Trek must be "Beam me up, Scotty," but a close second would be "He's dead, Jim." In episode after episode, Dr. McCoy arrives to examine a prone crew member. He waves a wand-like instrument over him, then looks at Captain Kirk, and says "He's dead, Jim."

I think that's how we want the determination of death to go. We don't want folks to die, but if they're going to, we want a clear pronouncement. Not "Well, he's dead by Criteria Set 4, but still alive by Criteria Set 2."

Now we are never told what precisely Dr. McCoy's tricorder registers, but perhaps it takes the measure of the three body systems that this report focuses on: The heart and circulatory system; the lungs and respiratory system; and the central nervous system, and, in particular, the centers involved in breathing.

The fact that he uses a medical device of some kind does suggest that his verdict, while stated apodictically may, in fact, be based on evidence that is harder to discern and more ambiguous.

We've long known that there can be ambiguity surrounding death. There can be illnesses and conditions that mimic death. Think of all those folks unfortunately buried alive in the stories of

Edgar Allen Poe. There are also drugs and potions that can deliberately mimic death. Think of the friar's description in Romeo and Juliet:

Take thou this vial, being then in bed,
And this distilling liquor drink thou off;
When presently through all thy veins shall
run
A cold and drowsy humor; for no pulse
Shall keep his native progress, but
surcease;
No warmth, no breath, shall testify thou
livest;
The roses in thy lips and cheeks shall fade
To wanny ashes, thy eyes' windows fall
Like death when he shuts up the day of life;
Each part, deprived of supple government,
Shall, stiff and stark and cold, appear like
death;
And in this borrowed likeness of shrunk
death
Thou shalt continue two-and-forty hours,
And then awake as from a pleasant sleep.

Interestingly, Shakespeare mentions three tests: the pulse, the breath, and the "eyes' windows." The three seem to roughly match our existing standards for a determination of death: the cessation of circulatory function, the cessation of respiratory function, and total brain dysfunction.

I suppose it would be too much to ask doctors to use Shakespeare's more mellifluous language, but it is a remarkably clear set of bedside tests: "no pulse shall keep his native progress," "no warmth, no breath shall testify thou livest," and, last, the "eyes' windows fall."

In the past, it seems that what was likely to be obscured and hidden from view was the presence of life. We could be fooled by the outward appearance of death and overhasty in consigning the living to the places of the dead.

With the advent of life-prolonging technologies, particularly the mechanical ventilator, there is a new twist on the old ambiguities and mistakes. A device meant to save life may, we are told in certain situations, only mimic or simulate life. We have been assured that death may, in fact, occur, despite some of the signs and likenesses of life continuing as a result of medical artifice. So what is obscured and hidden from view now is the presence of death.

That itself is progress. It's surely better for death to be disguised or unperceived because of the work of a ventilator than for life to be disguised or missed because of a mistaken judgment. Not nearly as much harm is done when we err on the side of life.

This report, "Controversies in the Determination of Death," does a fine job of setting forth the evolution of thinking about the standards for determining death. It traces the emergence of an alternative neurological standard of death in the 1970s to supplement the traditional cardiopulmonary standard and examines the continuing challenges to that standard.

It turns out there are some overlaps between our work on this issue and our work on organ transplantation. There is a hint that transplant politics may have played a role in the pressure to

formulate and adopt the neurological standard of death, just as it is playing a role now in the pressure to make certain alterations in the neurological standard, moving from a strict whole brain focus to a looser consciousness-related formulation.

While I find this linkage disturbing - and I confess it makes me inclined to be a bit suspicious of the neurological standard - I also believe that it's best to assume good will on all sides in scientific, intellectual, and even political debate.

Even if the neurological standard was in part motivated by a desire to create the heart-beating dead-donor category, the question still remains: Is the category a true one? Are there heart-beating cadavers and ventilated corpses such that we need a neurological basis for the determination of death?

Admirably, the report takes up this question in Chapter 4, first laying out the reasons for doubt that were posed originally by Hans Jonas and elaborated and updated more recently by Shewmon and then, most ambitiously, attempting to answer those doubts and defend the neurological standard with a new and better biologically-based rationale.

The debate concerns the meaning of wholeness. Instead of looking internally at the presence or loss of somatic integration, the report suggests that we look at the organism's relation to the external world. A living organism is in need of and open to commerce and exchange with its environment. Spontaneous breathing is a crucial manifestation of such openness.

The report even states that this "commerce with the surrounding world" is "the definitive 'work' of an organism." When the drive for such commerce is irreversibly gone, as in total brain dysfunction, then the individual is dead.

I don't know quite what to make of this argument. To a political scientist, used to thinking more about the body politic than the individual body, it's certainly intriguing. According to Aristotle, the wholeness of a body politic is a matter of internal structure, integrated functioning, and purpose. It's more about domestic politics than about foreign relations or commerce with the world.

This difference in self-sufficiency between bodies politic and individual bodies may just be a sign that the analogy is flawed and that bodies politic are not living organisms. Still, it seems to me odd to say that the wholeness of a living organism hinges on its needy openness. Apparently the wholeness of organic life is not whole in the sense of complete or unified.

But even granting that organisms have a needy, outward-directed mode of being, is it correct to say that satisfying this need is the definitive work of an organism? Isn't it just a precondition of the real work? If that precondition is met by artificial means, like a ventilator, some at least of that internal work of the organism continues. Would the fact that the body uses the supplied oxygen be an indication that the drive for breath is present internally, even if it's not capable of independent external operation?

Most astonishing, I thought, were the cases of pregnant women diagnosed with total brain dysfunction whose bodies continued to provide support to the developing fetus for days and even months.

My uncertainty about the line between life and death would, I think, have inclined me to resist the neurological standard back in the 1970s. However, that same uncertainty leaves me inclined today to accept the settled, majority view of the medical profession.

Nonetheless, the debate seems to me salutary. Openness to new evidence and arguments is as much a part of the scientific enterprise as spontaneous breathing is to the living organism.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Schaub, for opening up the discussion leading us into a number of serious issues and questions. I really appreciate it and thank you.

Dr. Schaub's comments and the staff paper itself are now open to discussion by members of the Council. Does anyone wish to - Dr. Bloom?

DR. BLOOM: I sent these comments to Alan. It seems to me that there are three general points.

This draft is much better to me than was the original, but I think we go still too far overboard in paying attention to the objections of Shewmon over and over and over again. It seems to me that confronting his issues and then rebutting them is sufficient. But we go through it in almost every chapter, and it seems to me to give more credence than that set of views demands.

Secondly, I think we still go too far overboard in muddying the distinction between why we're doing this and the issue of organ allocation. Once we've said in the beginning that we're not doing this for organ allocation but we're doing it to define a standard by which futile treatment of irreversible damage is no longer possible, that seems to me to be a much more sufficient and clean medical distinction as an end point, rather than to keep bringing up the consequences of this for organ allocation. That's being dealt with in another report that we're doing.

And then there was one rather egregious error in terms of where the antidiuretic hormone is released that needs to be taken care of.

But those are my three general comments. I had a lot of little nitpicking comments. But those are my two general conclusions and the error.

CHAIRMAN PELLEGRINO: Thank you very much. Thank you very much, Dr. Bloom. That's precisely what we would like to hear, the careful analysis of this particular presentation.

Let me say that we'll be asking all of you at the end of this discussion over the next several weeks to provide us with further comments in writing and, as has been the custom of the Council from the beginning, Council members may present their own opinion of the matter, and I appreciate very much the careful thought you've given to it, and we'll certainly correct that matter of the antidiuretic hormone. Several of us missed that.

Dr. Alfonso Gómez-Lobo?

PROF. GÓMEZ-LOBO: Thank you. I wanted to take up one of the points raised by Floyd just from my own perspective.

I think the reason to go back to Shewmon's position is that, if Shewmon is correct, it's really a major challenge to the idea that whole brain dysfunction is an adequate criterion for death. I mean, if it's true from his meta-study that there are all of these functions that continue to be discharged by the body - I'm looking at Page 36, for instance - such that he can talk about chronic whole brain death, then, of course, that is where the main challenge is at present it seems to me.

I mean, if, indeed, the rationale for the Harvard Commission is not correct - in other words, if it is simply not true that the brain discharges the function of providing for the integration of the body such that there is a number of functions, integrated functions, that continue after that happens - it is a major problem.

I must confess, being an outsider of these matters, that I'm perplexed. I would like to see the arguments really set out on both sides. I would even go as far as wanting to have Dr. Shewmon testify. I mean, I really want to see what's the depth of his thinking on these matters.

Now if you think that the evidence is inadequate, that Shewmon's position can be dismissed because, say, there's a misdiagnosis of the case of whole brain death, that's another possibility. But I would have to see the evidence for that. Thank you.

CHAIRMAN PELLEGRINO: Thank you.

DR. BLOOM: Well, I'm sure others will contribute to this discussion. But my comment in the margin of Page 36 is that none of these equal a living person. And I have no idea who Shewmon is and from what basis of experience and knowledge he draws his opinions, but I find them fallacious.

DR. FOSTER: Could I just say also that I don't know what the evidence is for, I mean, real evidence on any of these things like that the immune system is still working and fighting off infections. That seems to be a bizarre claim to me. I mean, what is the evidence for that? I mean, there's not evidence at all.

And amongst the other things, by the way, Renin is misspelled in that chapter. It's R-E-N-I-N for whoever is doing that, so.

Anyway, so I agree with Floyd about that. There are these enormous claims. And meta-analyses do not really answer anything, I don't think. But to make these, I said the same thing. All these claims that a brain-dead person can do, like an intact immune system, I don't know where that comes from.

PROF. GEORGE: Just so I can be clear, Floyd, are you and Dan disagreeing on the question of whether these are good indicators of death or life, or are you disagreeing because Dan doesn't think that what we would ordinarily call a brain-dead person is actually capable of manifesting these factors set out on Page 36?

DR. BLOOM: Well, my take is that, even if they were true, they wouldn't be life. Now, Dan is questioning whether they're even true. But even if they were true -

PROF. GEORGE: Dan, from your point of view, if they were true, would that manifest the existence of organismic wholeness or integration so that we would have a life?

DR. FOSTER: No. I would not. I agree with Floyd about that. I don't, and I want to make it clear. I have not made a systematic study of this. You know, if you're going to ask a question, a scientific question, about the immune system or something, I have not studied all of the data. I've just looked at what he has said.

So, yeah, I don't think a part of something is life. Look, if I take a liver out of an animal, which I've done about a hundred thousand times, you know, and profuse it, it will do everything single thing that a liver in vivo does and in which you discover all sorts of things. It's working. We've done it for very long periods of time.

It would be a little unusual to me to say that the fact that this liver is working is some sign that there's life in the animal from which it came. That's a silly statement because the animal has obviously been euthanized. But the point is that the fact that an organ can be kept alive or stays alive for a period does not mean that there is any continued possibility of life.

If this was an argument that, if you stopped the respirator, somebody would start breathing again and would do that if that was possible, then you might have an argument I think.

The fact that something works for a while after that, I mean, these things work all the time. We take out hearts, and, you know, we fly them across the country and so forth, and it will still work, I mean, to do that.

So, yeah, my point is two, Robby. I mean, this is not a big thing to me, this whole issue that we're talking about here. I mean, dead is dead. I mean, I don't know how many times I've declared it, just what the initial comments were.

But my points are two. I'm suspicious of the evidence that's had such an emphasis in this paper because I don't know where that came from. And as a physician scientist, it looks very doubtful to me, the claims that he has said here. The second thing is, to me it doesn't alter the argument that the person is still alive just because, let's say, the nails grow or something like that.

PROF. GEORGE: Dan, if you removed a heart or a liver from an animal, would it be possible that that part, that organ, could fight infections or maintain body temperature? These are what the claims -

DR. FOSTER: That's not really something that a liver or a heart does anyway, you know, I mean, that does that.

But I'm also very suspicious. I mean, I think he says that the body temperature drops. You know, it's not maintained at a normal fashion. With blankets, yeah, I mean.

CHAIRMAN PELLEGRINO: Dr. Kass?

DR. KASS: Thank you. Let me make a couple of general comments. I also agree with Floyd that this is a much better draft, and I've provided both the micrographic comments and also a slightly longer comment which I think would help beef up the argument defending the use of the neurological standard. I sent it too late by e-mail, and there are copies here for you to look at as you wish.

And I also think perhaps we've made too much of Shewmon. But the fact that the question has arisen and that there are still a lot of people who talk as if there's brain death and then there's death indeed, it's probably useful to try to clarify this in the way in which this report is done. And I think this is a very valuable contribution, and I'm very happy to see its evolution to its current form.

Second, the Harvard criteria report, notwithstanding the mixed motives, I think, did a very fine job in laying out the criteria for determining whether you still have a living human being in the presence of a ventilator which might, in fact, mask the truth of the matter.

They were very careful not to elaborate any concept of death or give even some kind of theoretical justification. It's a set of operative tests, and those tests more or less continue as we have them.

The trouble started when people tried to articulate the justification for this in terms of some understanding of why the complete dysfunction of the entire brain constitutes the equivalence of the death of the organism as a whole. And in that paper by Bernat, et al., the concept of integration took very great prominence. And it seems to me it is that which Shewmon is after when he raises at least some of these objections.

And, I mean, I would share, I think, Dan's desire for more evidence on many of these points. But I would be inclined to think that certain things, at least in some cases, have been noted.

But those kinds of somatic integration don't, it seems to me, add up to the existence of the living organism doing the work of the organism as a whole.

So here I think, this is Floyd's point, and you also agreed with it. I would grant Shewmon all of these things and say "very interesting." But even in the presence of those things, one could still say that the organism as a whole is no longer with us.

And here, just a small comment to Diana's very elegant opening. I think the emphasis on commerce with the environment does make it look as if foreign relations are of the essence, and this comes out, I think, in my suggestions for redrafting it.

I think what Alan wrote and is really very nicely hit on is, let's not talk about integration. Let's talk about the work, the essential work, of the organism. The essential work is its capacity to maintain itself, and that activity of self-maintenance requires, on the one hand, an inner drive to do so, the ability to act on the environment at least minimally to provide that without which there could be no organic life, and some kind of responsiveness to the world, at least minimal responsiveness.

And it turns out that he's given a kind of intellectual justification for using these criteria that the Brits use, which is to say, no awareness and no breathing. If you can't do that, you can't *do*. That's the ground. That's not the highest thing that an organism does. That's not the reason that all of us want to stay alive.

But absent that foundation, there isn't anything. So I think this report stands a chance of rescuing the criteria giving it a sounder, not foolproof, but a sounder philosophical defense in which Shewmon's objections can be acknowledged and bypassed. And I think this is a real contribution and would give lots of people much greater comfort that the doctors who proceed primarily without these philosophical reflections are doing the right thing.

CHAIRMAN PELLEGRINO: Thank you. I have Dr. Meilaender and then Dr. Dresser.

PROF. MEILAENDER: I want to make one comment about Floyd's second point and then a comment about the most important issue that's arisen.

Your point, your second point, Floyd, was something like there was too much emphasis at the start on the organ-transplantation allocation issue, and the alternative that you suggested was, sort of, when treatment is futile.

To me, that doesn't quite get it right because the issue is, the real question is, it's not just organ allocation. I agree with you on that point. The question is when you have a corpse. And if you have a corpse, it's not that certain treatments are futile. It's that the very concept of treatment ceases to be relevant any longer. And so I just wanted to sort of clarify that in a way.

Now to this other issue. I mean, I can't evaluate Dan's and Floyd's objections to Shewmon's thing. I've taken it seriously just because people in the bioethics world seem to have taken it seriously. I have no better reason than that, I suppose, for doing so.

But it has been taken as a serious challenge to the use of the concept of integration as sort of the mark that we're looking for to distinguish between a living and dead being.

I mean, I think it's true. Dan's illustration of the liver is nice. The alternative that's being developed here is that it's not just that the body continues to be able to integrate certain functions of one sort or another, but that the living being is still present.

And the attempt to provide a different account of that here, I think, is a really potentially excellent contribution. At least it seems to me that. I mean, it's not clear that the integration concept in and of itself works.

We've got something else going here, what Leon just summarized a moment ago. And I find it both interesting and potentially significant as an alternative explanation of why total brain dysfunction

seems to us to be so significant.

I actually think also - but this sort of goes beyond what we need for this report - that it's a philosophically fascinating alternative that's being offered, what Leon just characterized as the organism's capacity to maintain itself shown in both an inner drive and an openness to the world.

I mean, there's something quite interesting in the fact that maintaining oneself requires an openness to the world. I mean, I think actually the implications of that are much larger than just a question about transplantation.

So I think we have a potentially really significant contribution here saying something that hasn't - it's not that nobody has said it before. But it hasn't played the important role in these discussions that it could, and I think it's a very useful thing to put forward.

CHAIRMAN PELLEGRINO: Dr. Dresser and Dr. Hurlbut.

PROF. DRESSER: I, too, think that the report is much improved, much more accessible and clear to educated lay people, and I really congratulate you on that.

A couple of specific things. On this list by Shewmon on 36, I know from the movies, I think, that when people die in the ordinary way their hair grows and their nails grow, and I was wondering if there are other things that apply to people declared dead by the cardiac standard that could be cited as examples of things that continue to go on but we still consider them dead, to respond in part to him.

The second thing I wondered about was on Page 10 where there is a discussion of acknowledging whole brain death, we can't really know that those people are dead. But organ transplantation is a benefit to society that we want to maintain even if we cannot know that the donors are dead.

The main proponents of the view that we should abolish the dead donor rule in my reading are the ones who want to say more like, "Well, maybe the people with whole brain death are dead. But there are other people who don't meet that standard. There are severely brain-injured who are close enough that we should be able to take their organs."

So the way this was presented struck me as a different framing of that argument. Later on, the other one is presented. So I just wondered if whether that was something that would be confusing or kind of throw people off. So that would be something to think about.

And then the third thing was in the donation by cardiac death toward the end. I thought that part was a little bit too truncated. For example, on 47, it's discussing this irreversibility question and mentions at the end that traditionally physicians don't rush to declare death, and it's kind of a notion of recognizing the dignity and the mystery and the dying process not to run to somebody's bedside and say, "Okay. They're dead." And I thought that was good material.

But then I wondered, "Okay, well, what is the point?" The next paragraph just kind of says, well, this is something society needs to think about. And I just wondered if we could do a better job of drawing some conclusions or sort of just finishing off that part in a more eloquent way.

But other than that, I thought it was very, very well done.

CHAIRMAN PELLEGRINO: Thank you, Dr. Dresser. Dr. Hurlbut?

DR. HURLBUT: So I want to get back to what Floyd started and try and engage Floyd and Leon in this dialogue because I think there might be something really substantive there, and Dan, too, here.

First of all, I know Alan Shewmon personally. I've talked with him about these matters. He's a neurologist on the faculty at UCLA, at least he was when I talked with him. I haven't talked with him in three or four years, maybe a little longer.

And I think what he's doing here is something that is, indeed, thoughtful and challenging to us and important for us to consider. He's a very thoughtful person and a very earnest person.

And I think we should take seriously what he's saying, that if we're going to fairly superficially define life and death by some notion of somatic integration, then we have to take seriously that, as he says, the functions of the body that one would say define integration are, in fact, whole body properties, that they are emergent properties of the whole, and that they reflect the well-working whole and they reflect what the organism as a single unit does.

So then the question becomes, well, if there are systems - and Dan may be right. He may be exaggerating these. But if you look at what he's saying, he says there are these troubling evidences on the edges of this. This meta-analysis may or may not be right, but there are enough troubling issues here.

He points out that certain body functions do seem to involve more than what you might call a part. They involve numerous parts of the body acting together. And so then the question becomes, well, now are these really what you would call somatic integration in the fullest sense or are they just subsystems?

And there's where I think we might have traction on what Floyd is talking about, that, in fact, just as the body has parts, it also has distributed subsystem functions that don't rise to the level of what we could reasonably call the action of the organism as an integrated unity. And that's where I think we might get some traction, and I'd like to ask you to further explicate that.

But just a couple of more comments before you do that. I think what Alan is worrying about is, we all know now that DNA essentialism isn't a very good picture for how genetics works. It puts the emphasis too much on the DNA, which, in fact, is just a component of a larger system.

I think what he's getting at is, we have to be careful of not establishing what we might call neural essentialism to say that the person is the neurons operating in a certain way.

But what I would like to suggest is that, while there may be subsystems of the body, these subsystems are, in fact, joined and become integrated when the brain is operating. And when it isn't operating, they are fragmentary subsystems, and you can go on with that.

But I'd also like to put a question to Leon and that is, what do we really mean by integrated unity for an organism and might not this integrated unity differ in the kinds of organisms we're talking about? And I'm thinking specifically here about parasites.

To me a crucial term in all this might be the self-subsistence that characterizes an organism, and, yet, there are differing degrees of passive and active natural existence for organisms. And here the ventilator almost feels like the relationship between a host and a parasite where something is supplied that other organisms supply for themselves.

So the question then becomes, do we need to define human wholeness, human integration, by somewhat different criteria than we might for other organisms? And that brings us back to the special types of active agency that human beings have.

And so I would specifically like to ask you to articulate, Floyd, what you would find inadequate about Alan Shewmon's ideas and what you would define as the integrated unity of the organism, and to ask Leon, specifically, what he might say about the species-typical dimensions of commerce and whether there might be something specific to human beings that we might focus on?

And, finally, I do want to get back to this one or at least mention it, if it's appropriate now, and that is, beginning on Page 6 in our report we use this word "health" I think a little casually. It says, "This means that surgically procured organs will be in relatively good health," and, of course, "health" means wholeness, and that's really what we're trying to get at in our definition.

And I just want to raise the question for the Council as to whether we should reserve this word "health" for what we're really talking about: namely, the well-working whole. And I know it's used colloquially. "Their healthy organs have been procured from the dead donor." But I wonder if that is something we ought to not fall into, but speak of health in its proper relationship to the living whole.

So what do you think, Floyd?

CHAIRMAN PELLEGRINO: Dr. Bloom and Dr. Kass?

DR. BLOOM: Just to be very succinct in my responses, the reason I raised the issue of who is Shewmon is that, if I had known he was medically trained and a neurologist, I would have given more than just passing attention to what his comments were.

If his background was in philosophy or law or something else, these would be things that he had read but not necessarily been able to interpret. So giving even a footnote of background on who he is at least establishes for me that at face value I have to listen to what he has to say even though I think he's wrong in what he has to say.

And, secondly, let's take some examples at the periphery where all of these things are going on. The

person is even breathing, but they are not interacting in a constructive or a responsive way with their environment. Are those people alive or dead?

The Schiavo case, the Karen Quinlan case, where death was only allowed by virtue of stopping the feeding tube, because all these things on Page 36 were going on but that person was not in their environment, I would have said that maintaining that, as the physicians who made the decision finally did, that this was futile treatment, that there was never going to be any recovery and the case should have been closed.

You can get by with no kidneys, you can get by with no liver, you can get by for some time with no heart, and the brain is still functioning. Those people have an opportunity to be repaired. But when the brain isn't there, it doesn't matter what the rest of the body is doing. That person is never going to be a person.

CHAIRMAN PELLEGRINO: Dr. Kass, do you wish to comment to Dr. Hurlbut's question?

DR. KASS: I'm first moved, Floyd, if you don't mind, to underscore something Gil said in response to the last time the notion of futility was raised by you.

It's very important, at least for the purposes of this document - and maybe not everybody agrees - that we distinguish the question of when continued treatment is futile because no good will come from it and when what looks to be treatment is mistreatment because you have a corpse whose corpse-like nature is hidden by the fact that the chest is heaving.

And no one, I think, would say that Terri Schiavo was dead. She might have been dead as a "person," whatever that means. But no one would have buried her. One might have been warranted or not in taking the feeding tube out, but that was a decision to discontinue life-sustaining treatment, not a question about pronouncing her dead.

And I think we should remain very clear about the confines of this report. I don't think you disagree, but I think the wrong impression might have been conveyed.

Bill's question, I'm not prepared to do very much with on one leg, but I don't think you could talk about the many complicated ways in which the human being does all of the human work.

The question at the margins at the edges of life is, "Is there still the human organism present?" and not, "[Are] the powers to philosophize or to make moral judgments present?" Those might enter into the question of how vigorously to treat or not. But the question here is, is the patient still here or not? You know, is it still a member of the human community or is it time to call the undertaker?

And for there, I think you're talking about kinds of minimal and foundational activities of the work of staying alive without which none of the higher things are possible and in the absence of which I don't think you would say that you have an organism.

And here I think the difference between the living human being and the living chimpanzee, the living or dead human being or the living or dead chimpanzee or the living or dead dog are probably very comparable. Parasites and amoebae and bacteria are, you know, far away.

But I think we're talking about a mammalian organism, the life and death of which looks fairly similar. I mean, I could be disputed. I think Floyd and Dan might have a different take on this. But I don't think you need a kind of fancy account of the specifically human character of the organism to look for things that are distinctively human in deciding whether we've crossed the line from living or dead. I don't know if others would agree.

CHAIRMAN PELLEGRINO: Dr. Lawler and Dr. George?

PROF. LAWLER: I'm approaching this from the discredited foundation of philosophy and law -

(Laughter.)

- and I think it's a real problem here from a common sense point of view.

We do want to know when a corpse is a corpse. We do want to know when dead is dead because you can have "truth" in quotes. You can have "morality" in quotes. But you don't want to have "dead" in quotes, like "post-modern dead."

Although in the short term, there may be some question. In the long run, we know death when we see it. It's just this gray, maybe gray, area among the newly dead that causes us distress.

And I think it was well put. It's not, you know, when is treatment futile, which was the Terri Schiavo issue, but when is treatment utterly ridiculous because you don't treat corpses. And most of us wouldn't want to cross the line when it comes to organs, of taking organs from beings who aren't really dead, not sort of dead or will be dead soon or something like, but actually be dead.

So I think Shewmon has caused in the world of bioethics real doubt. That is, integrated, somatic functioning, which was the basis of the medical consensus, turns out to be a question because there does appear you can give an argument that the being continues to have that kind of integrated, somatic functioning even if the brain is *not* working.

So why would anyone care about this? Why would an average guy like me care about this? Because some people want to give the most expansive possible definition of life. When in doubt, go with life.

So a lot of people want to protect embryos, not because there's a slam-dunk ontological case that the embryo is a human person, but because the embryo might be a human person. And when in doubt, choose life. And in the same way, when in doubt, choose life, and so the guy on the ventilator whose brain is not functioning might be alive; therefore, choose life.

So I do think people of good will are shaken by Shewmon. People of good will who read stuff like that are shaken by Shewmon. So we need a new argument, and the big question before us is, is the argument of needful openness really a slam-dunk argument? Question number one is, that's a slam-dunk argument. Or the other point of view of Dan and Floyd is, we don't need a new argument because we weren't shaken. But some people have been shaken.

But that means a need for openness becomes a question because it's so darned philosophic and so darned interesting and so darned complicated, as Diana pointed out, and perhaps so darned questionable in its own way.

So does needful openness solve this problem that's come before us, or does needful openness show us that we have a pretty good argument here? But because it's philosophical in a certain way, does it really provide what we really need to extinguish the doubt or were we wrong to think there was doubt that needed to be extinguished?

But in Diana's remarks, she said at the very end - I think she was saying - I have some doubt; nonetheless, I'm going to go with the established medical consensus anyway.

CHAIRMAN PELLEGRINO: I have Dr. George and Dr. Gómez-Lobo.

PROF. GEORGE: Thank you. I agree with Floyd that we need a footnote telling us who Shewmon is. As it happens, I know him and know about him. He is a person of distinction. He is a clinical professor of pediatric neurology at UCLA, and he's the chief of neurology at the Olive View UCLA Medical Center.

But if we're going to engage the work of a person, any person, in the extensive way we do in this draft, then we need to tell readers as well as ourselves who the person is.

Shewmon has become a very important figure, I think deservedly so, in bioethical discussions. And his work is engaged and treated with respect interestingly across the spectrum of views in bioethics. But I think it is important that we understand that, you know, his principle contributions are in his area of expertise, and this has to do with factual scientific claims of the sort that Dan has doubts about and wants to know more about and wants to know the evidence about.

He's also intervened or entered into the neuroethics debate and the bioethics debate, and there, you know, he is certainly a welcome participant and has interesting things to say, but they are not within his specific area of professional expertise, and so I think a distinction can be legitimately drawn there.

So what I would suggest is that we do look closely at the specific scientific claims, factual claims, being made by Dr. Shewmon. And perhaps it would help Dan if we instructed the staff to look at the literature to see what criticisms have been advanced if, in fact, there are criticisms, and I suspect there must be if this has struck you right out of the blocks as having problems. We could have the staff look at the criticism that's emerged in the literature of his scientific claims.

Now I know there's plenty of criticism on the ethics. But, again, that I think is secondary to the specific use being made of Shewmon here. So I think that's one specific suggestion that I hope we can make to the staff because I think it would strengthen the report.

Because of his importance in bioethics and the importance of the questions that he raises, I'm in favor of retaining an extensive engagement with Shewmon in the document. But I'm proposing to enrich it by looking at what critics have said.

CHAIRMAN PELLEGRINO: Dr. Gómez-Lobo. Thank you.

PROF. GÓMEZ-LOBO: I'm glad that we're having this discussion around Shewmon. But now I would like to support something that I understood Leon to have said a few minutes ago, and I emphasize it because I think it should be something like a common ground in these discussions; namely, that the notion of death has to be a notion that transcends classes of living beings.

I think we have one basic understanding of death, and it is the permanent cessation of life. Stones don't die, but trees and birds die. And this may seem trivial, but I think it's not because much of the literature on this subject is entitled, for instance, changes in the definition of death. And that, I think, is a very serious philosophical error.

If you change the definition of the term, you're talking about something else. If you change the definition of a triangle into a plane figure with four sides, then you're no longer talking about triangles.

I think for the sake of clarity it's important to realize that we and the generations before us are talking about the same phenomenon. It's the cessation of life of organisms of any kind.

The debate is, as the report and its very good draft that reads, a debate about standards, standards or criteria for establishing this. But there has been no change in the definition of death. In fact, if it were, we would be talking about something completely different.

So I would suggest, and the report I think does this, to keep that as the ground floor. We are discussing standards. We are not discussing new definitions of death.

Thank you.

CHAIRMAN PELLEGRINO: I have Dr. Schaub, Lawler, Meilaender, and Dr. Rowley. Thank you.

PROF. SCHAUB: Yes. Just a very quick question maybe to Leon about the drive for self-preservation. Why wouldn't we say that things like the sexual maturation of a BD child or the gestation of a fetus, how is that not indicative of the presence of a drive to self-preservation and, not only self-preservation, but the next generation?

CHAIRMAN PELLEGRINO: Can I interrupt the flow to give Leon a chance to respond to Diana? Yes, please.

DR. KASS: No. This might not be right, but my first impulse would be to say that if you could perfuse and ventilate a corpse so that it becomes simply an, as it were, incubator for a life that happens to reside there rather than see it as the continued work of what would have been the mother, I imagine it would be possible to sustain fetal life in lots of unnatural places and this would be one of the first such.

PROF. SCHAUB: Could a BD woman conceive?

DR. KASS: Could a...?

PROF. SCHAUB: A brain-dead woman conceive? Not only gestate a fetus, but conceive?

DR. KASS: I'm going to declare ignorance, Dan.

DR. FOSTER: Well, I think that would be miraculous. I mean, I don't want to get into the integration of the CNS (central nervous system) and so forth around here. I mean, there is powerful new information, for example, that neurons in the brain control the metabolism of glucose in the body. This is a new *Nature* paper that's just out.

The intricate hormonal changes that allow one to not only conceive but then to bear a child are so complicated. Look at what we have to do to try to [conceive children through artificial means], you know, I mean, to do that.

So somebody who has tested brain dead? I mean, you know, Lazarus rises. So maybe that would happen. But I would be very skeptical about that because of the intense integration of multiple organs to allow a fetus to be formed and, you know, and to grow to -

PROF. SCHAUB: But we do know that gestation has taken place for periods of weeks or months.

DR. FOSTER: Well, I think Leon's statement - again, this is not something I know a lot about or really am very interested in. But what he said is presumably one of the things that we talked about in stem cells, would it be possible for us with an artificial uterus to raise parts and so forth along those things?

What Leon said is, "Well, okay, if you put a fertilized egg in an artificial uterus, you likely would see it grow up to some point." So I don't think that's what you're asking. I think you're asking by normal courses, could you get pregnant or along those things?

I don't know this, but I'd be pretty doubtful, for example, that the changes in vaginal lining and everything else are normal because you're not generating. You know, you're going to have panhypopituitarism and everything else, I would think. So I don't know the answer to your question, but I'd be very doubtful.

CHAIRMAN PELLEGRINO: Dr. Lawler?

PROF. LAWLER: Let me just underline that the whole premise of this report is that Shewmon's challenge is important, and the great thing about the challenge is it's spurred us to deeper reflection about the distinction between life and death.

So let me just read the sentence right in the middle of the page on Page 41, the third paragraph. "Thus, total brain dysfunction can... continue to serve as a criterion for declaring death, not because it necessarily indicates complete loss of integrated somatic functioning, but because it is a sign that this organism can no longer engage in the sort of work that defines living things."

So the point of our report - and I think it's a really important report, very well done - is that given this doubt, we need a new argument. If the doubt is not worth considering as a genuine doubt, then we don't need a new argument.

But I actually think, my own opinion would be, the argument is presented brilliantly. I'm like 98 percent persuaded by it. And from that point of view, it's a really great contribution to our understanding of what death is. But if Shewmon is bunk, then we don't need it.

CHAIRMAN PELLEGRINO: Dr. Meilaender and Dr. Rowley.

PROF. MEILAENDER: Well, this may not be necessary now that Peter made his most recent comment which seems to me to cut, you know, in a little different direction of his earlier one.

I was going to reply to his earlier one where he had said that this new argument was so complicated. And obviously it is complicated in one way. I'm not sure it's any more complicated than the argument it intends to replace about bodily integration.

In another sense, it's very simple. It's an attempt to provide a very basic kind of understanding or explanation for why we've been drawn to the sort of standard we have for distinguishing between living and dead human beings.

So, yes, it has its complications, but I think in another sense it's very simple. And I'll just repeat, to come all the way back to Diana's opening remarks, that part of the attraction of it to me and part of what strikes me as right about it is that what it recognizes is that you can't actually entirely distinguish between domestic and foreign policy, that the two are inevitably connected in a living organism.

CHAIRMAN PELLEGRINO: Thank you. Dr. Rowley?

DR. ROWLEY: I have three short questions or comments.

On Page 14 at the top under Item 3, the staff says, "The concept of death and the selection of the appropriate standard for determining it are not strictly medical or technical matters. They are in large part philosophical."

And I wonder. That struck me as strange because I have thought of death and the standards; i.e., firstly, the loss of cognitive function as well as the loss of respiration and cardiac [function] are standards set by medicine not by philosophy. But I raise that as a question. That struck me as strange.

The second question that I have, I, as well as I think most members of the Council, received an e-

mail from Mike Gazzaniga, who was unable to be here today, about a report from the Vatican. Now I haven't seen that report, and at least Mike was very laudatory. So I think that, as we are working through this report, it would be prudent for us to have access to that because I gather from his comments that the Council assembled by the Vatican did agree in the concept of brain death.

And that leads me to the third comment which is, we've chosen to use a new term "total brain dysfunction." And I wonder if that's really going to be useful in this in the context of trying to help resolve some of the issues that we've been dealing with. Thank you.

CHAIRMAN PELLEGRINO: We have time for one or two more comments. Leon and Dr. Lawler.

DR. KASS: Mr. Chairman, this isn't so much a comment as it is a question. In the draft we received, there is a blank page at the end which says, "Council Recommendations/The Position of the Council."

What kind of thing might appear there? I mean, are we going to be asked either individually or collectively to weigh in on one or another of these views? That's just, you know, a question.

CHAIRMAN PELLEGRINO: Questions? Comments? Peter?

PROF. LAWLER: I did with someone else's help a quick Google search on the Vatican and on this issue, and I just came up with the news service blurbs. So this is very unauthoritative and probably shouldn't be in anyone's record.

But nonetheless it seems that I discovered that the scientists that advised the Vatican are actually divided on this now. So Bishop Fabian W. Bruskewitz of Lincoln, Nebraska, whose paper from the 2005 meeting is included in *Finis Vitae* asked how the Catholic Church can accept a lack of brain function as a definition of death and yet still oppose the willful destruction of human embryos which have not yet developed a brain.

So I'm not saying the bishop of Lincoln is necessarily the world's greatest scientist, but he seems to be scientific enough to have presented a paper. And it appears at the meetings at the Vatican there was a disagreement over whether brain death is still an adequate definition of death.

CHAIRMAN PELLEGRINO: Thank you. Gómez-Lobo?

PROF. GÓMEZ-LOBO: I was going to say something similar to that. I think that Mike may be wrong in calling it a report because the Vatican publishes lots of things with which they don't agree. For instance, if you take the yearly reports of the Pro-Life Academy, there's lots there that are just the papers that people have submitted.

So I think we should take a look at these documents, but they don't reflect, say, something like official teaching of the Catholic Church in any way.

CHAIRMAN PELLEGRINO: Thank you very much.

DR. FOSTER: I would just make one other point about Mike's thing. We talk about Shewmon being - you know, he's the head of pediatric neurology at a private hospital, I guess, that's associated with UCLA.

But Posner, who is quoted here, clearly is the senior neurologist, you know... I mean, that would be a person who is universally recognized at a different level of clinical neurology, I think, in terms of this... And if he was quoted correctly, he would be very much in agreement with the sense that the brain is absolutely critical to life, you know.

You can define life. If you listen to my lecture to biochemists at the medical school next week, you will hear my definition of life, and it's a molecular definition. Life is the capacity to generate high-energy phosphate bonds. Death occurs when you can't generate ATP. Okay? That's what death is because that's what keeps everything else going at a molecular level.

So, you know, the arguments vary one way or the other about what you define and how you want to define it.

CHAIRMAN PELLEGRINO: Thank you.

DR. BLOOM: Well, I just wanted to respond to Janet's third point about total brain dysfunction not being the most mellifluous way to express what it is we mean.

And I had suggested to Alan that we might consider using the term "brain failure."

Heart failure, liver failure, kidney failure are all well in the public's mind, and they're not necessarily specific as to the mechanism by which that organ has failed. And what we're talking about here is brain failure.

PROF. GEORGE: Could I ask Floyd a question about that, again, just to be clear?

Floyd, when you talk about brain failure, are you talking about what afflicts a person who is in a persistent vegetative state, or are you talking about what we have heretofore referred to as a brain dead person as opposed to a brain damaged person in a PVS state?

DR. BLOOM: I was talking about it in the sense that Peter's last quote from Page 41 talks about it and the inability of that individual to interact with the environment as the work of the individual.

PROF. GEORGE: So would a PVS patient have brain failure?

DR. BLOOM: It has a form of brain failure, yes.

PROF. GEORGE: So such a person would be dead?

DR. BLOOM: That's where we are.

PROF. GEORGE: But not according to the brain death definition that we have been working with and that Shewmon and others have called into question.

But I think it was Leon who said, I mean, no one was saying you can bury Terri Schiavo. The debate is about whether you could take steps that would result in her dying, the assumption being she was alive before those steps are taken. Am I wrong about that?

DR. BLOOM: I should let Leon answer that question because it was he who raised the actual complex dividing line.

DR. KASS: No. I thought I was going to come to your aid, Floyd, and say all you need is *total* brain failure. And you would say of Terri Schiavo, not quite total.

PROF. GEORGE: So she wasn't dead?

DR. KASS: That's what I think, I mean, by these criteria.

PROF. GEORGE: I'm happy enough to go along with the use of the term "brain failure" if it refers to what we generally refer to and have been referring to as brain death. Then we can talk about whether we want to retain that understanding of death.

But I would be very dubious about moving forward if we're identifying brain failure with death and we would understand people who were in persistent vegetative states as having brain failure.

CHAIRMAN PELLEGRINO: Dr. Carson?

DR. CARSON: I just want to bring it back to a practical level because, you know, as a neurosurgeon, we deal with these things of brain death and brain failure all the time.

And, you know, we in the medical profession know what a brain dead person is, and there really isn't a whole lot of controversy about, you know, ceasing to treat those individuals except if organ procurement is on the table.

However, the ones who have significant brain dysfunction engender a lot of discussion. People recognize that they are not dead. However, they also recognize that they are not people who are not going to make any kind of a recovery.

And in those situations, what is practically done after discussions with the family are measures are taken to allow them to move on to the state of brain death and then, you know, things are withdrawn at that point.

It's practical. It's done every day. And, you know, I just hope that we can reflect some of the practicalities of what is done in normal life in medicine.

CHAIRMAN PELLEGRINO: Thank you. Let me point out first in answer to Leon's question earlier, yes, we would like to have your comments on any recommendations we might make. I think

we would like very much as we indicate on the very last page of the material you have of the report itself to know what you think about that on an individual basis to repeat once again the invitation to each and every one of you to express your personal view on this.

I take this to be, just as all of you do, an extremely important question to be addressed. I'm very much concerned, Robby, about the question you asked toward the end about the permanent vegetative state. We had a presentation in which it was suggested to us that those patients were eligible for removal of organs, and I personally would certainly strenuously oppose that. But that's beside the point.

But on your question, Leon, we want to have further recommendations and further emendations if possible. This is important enough so that when we make the contribution it's clear that the opinions of the members of this Council are expressed, and it's not the kind of thing where we may be able to come to complete resolution of all the issues and make a recommendation that everybody would agree to unanimously.

But our purpose is to lay out those issues for the public and where are we on this important question, which leads me to the second point that this report, of course, is related to the report which will be given to you for the next meeting for a detailed discussion on organ donation which you've heard about and we're now at the point again where it has been edited and looked at again and again and will be back to you for further comment. So these two have a relationship one to the other.

And, Robby, to just point out quickly, your question about the critics of Shewmon, I think in [Alan] Rubenstein's summarization of the paper he did address the critics of Shewmon. I know that Dr. Bloom feels perhaps we've given too much attention to Shewmon, but Shewmon has raised the question over and over again and I think it needs to be dealt with.

Insofar as the Vatican position goes, I think Gómez-Lobo has reported on that. I'm a member of that Council as well. I won't take your time to go into the details of the conversation.

But my general feeling is that the members of the Council do, indeed, feel this is sufficiently important for us to give our very, very close attention to it.

Dr. Dresser?

PROF. DRESSER: In terms of recommendations, I think we could look at Pages 9 and 10 for a barebones statement of the sort of objectives of the report and then see whether that needs supplementation or there's some concurrences and dissents and so forth. But that seems to me to present a draft of recommendations.

CHAIRMAN PELLEGRINO: Thank you very much.

If there are no further comments, we'll break until perhaps, oh, 10:30 or 10:35 at the latest to reassemble. Thank you very much.

(Whereupon, the proceedings in the foregoing matter went off the record at 10:21 a.m. and went back on the record at 10:54 a.m.)

SESSION 2: THE "CRISIS" IN THE ETHICS AND PROFESSION OF MEDICINE: A HISTORICAL PERSPECTIVE

CHAIRMAN PELLEGRINO: Can I ask the Council members to be seated please? Thank you very much. We'll now resume our agenda.

The next topic for the rest of the day will be on the "Crisis" in the Ethics and Profession of Medicine. And we begin with a very distinguished commentator and author in this area, Dr. David Rothman.

I have explained to Dr. Rothman, who understands clearly, of course, our custom which is not to provide long introductions, and he said he was relieved, and I'm glad. And so I will ask him forthwith to address us and then the discussion will be opened when Dr. Rothman finishes.

PROF. ROTHMAN: Thank you. I can tease with Dr. Pellegrino. If you can accumulate enough titles, you don't have to give your talk —

(Laughter.)

— particularly, you know, when you get these 20-minute versions of it. I have longer today, and I very much enjoy the chance, [first], to appear before you and speak to you. I know several of

the members of this commission for some years. And, secondly, it's a good subject, and I'm hopeful that the pleasure that I got in sitting down and doing this for you will be matched by your finding what I'm about to say interesting.

Dr. Pellegrino and I are both members of that generation that came of age well before PowerPoint. Since I was in arts and sciences before going up to the medical school, I didn't even know from slides. We just simply talked from notes or text. Yet, I have converted and Dr. Pellegrino is suggesting to me — (maybe in [confidence] I'm not sure) — that he's beginning a little bit to convert to PowerPoint as well. It's a very useful tool. So I haven't used as many as I might otherwise have done out of respect for Dr. Pellegrino's bias. On the other hand, it was hard not to at least be able to say something using the technology.

I'd like to open my analysis of the state of the medical profession, the putative crisis it faces, and the locus of responsibility for making change by recounting to this august group how another group responded to the very same issues.

The group whose experience I'd like to share with you is the Board of Trustees of the Institute on Medicine as a Profession, IMAP, a 501(c)(3) public charity of which I am the president.

IMAP itself was created through a generous gift from a noted philanthropist, George Soros, a man who made his fortune in the marketplace obviously, but a man who was totally convinced that marketplace values should not dominate all sectors of the society. In particular, the professions, medicine and law, as the exemplars, have responsibilities that ought not to be driven by the market. This was very, very much his position, a position that I share, and I suspect many, if not all, in this room will share.

Doing justice from the legal side and promoting health in our territory are obligations that go well beyond the bottom line. It was that kind of thinking that led him to endow the Institute. The Institute itself carries out its work through a center at Columbia College of Physicians and Surgeons.

IMAP has a board of directors, trustees, if you will, and the first meetings post the gift were devoted to defining its mission, the Institute on Medicine as a Profession. As it would be expected, the group wanted to spend a certain amount of time defining professionalism, how it might promote it. But what might not be expected in these early deliberations was a dialogue that we got into and actually stayed into for a surprisingly long period of time. And it's that dialogue that I want to recount to you.

The first impulse of the group was to set out the challenge, medicine as a profession, and set it out in terms of a revival of professionalism. We have to look back, recapture, restore, you know, if you will, all the "RE" words. Recent developments have eroded professionalism, the opening hypothesis was, so our efforts should be revitalization, recovery. You can fill in more and more synonyms.

But before we even could go very far down that path, we all recognized a fundamental inadequacy of framing a program in terms of restoring — and I don't mean it quite pejoratively, but perhaps there's a little inkling of it — restoring the good old days.

So as the slide shows, we called it and we began to talk about it in terms of the so-called good old days. Did we really want to revive, restore, rediscover a profession that was all male, almost all white, and almost all upper-middle class?

I keep wondering. You know those photographs, you've lived with them. We have them at P and S [College of Physicians and Surgeons], too. You know, the class of house staff from 1910 and 1912. You know those photographs: Lily white, [and all] male. I mean, occasionally maybe a woman, maybe a person of color. But those are stark white photographs. And we do know the socio-economic origins, the upper-middle class, as well. So before one got too rhapsodic about going back to the good old days, certainly we didn't mean to do that.

And then we would go into financial issues, which we'll be talking about today. Conflict of interest was certainly present; fee-splitting, an absolutely common habit. The surgeon had to reward the referring physician. He did it in a variety of ways, sometimes the charade of that surgeon bringing in the primary care provider to the operating room. One way or another, they figured out how they could gift, if you will, the referring source. The practice hasn't altogether disappeared.

I love California wines, saw an advertisement in The New Yorker for a kind of California wine-of-the-month club, was curious about it. On home stationery, home stationery, I wrote and asked for the brochure. It came back with a first-cover insert kind of thing which said, "The perfect way to thank the referring physician."

(Laughter.)

Somebody at that wine company knew how to market its product. Fee-splitting isn't over. But, I mean, again, my caution is, we're not going to get so rhapsodic about the good old days.

Direct dispensing. A not uncommon practice.

Fee-for-service. In a group like this, I don't have to expound on the potentials of conflict of interest there. But certainly, you know, returning the patient for a visit, it happened, part of the roster.

Drug company largesse, which we'll spend some time on this morning as well. It's not a post-1990 phenomena. It goes way back and was, if anything, perhaps — well, I shouldn't say that. But its effectiveness may have increased. But it's certainly a phenomena as part of the good old days.

And even public complaints about doctors' income, which you see a lot of in the press, nothing really new about that. The 1950s saw a spate of journalist accounts of doctors including one that I always tell my medical students that involved a child in a Midwestern town who fell down an abandoned well.

He opens his book with this. The town spent about a day and a half. Everybody — you know, the fire department, the citizens — digging, you know, doing all the rescue operations. They rescued the child. They give the child to the physician for care. The physician delivers the care, and then the physician has the audacity to bill the family.

Well, this became newsworthy. How could you have billed? It made its way to the AMA. As I followed the story, I wasn't sure what the AMA would do. The public uproar was so great that the AMA said the doctor was wrong. I tell this story, not for the rights or wrongs of the charge, but that public complaints about physicians' income has a long history.

Damned if you drive the Cadillac, damned if you don't. Patients want their physicians to be "big men." On the other hand, you know, I mean, the only reason that I'm playing this out for you is I don't want you to think that the current kind of critiques have anything unusual about them.

And the last two bullets are, of course, perfectly obvious to you. The strong bias against group practice and the extraordinary bias against government intervention, the case in point, of course, being Medicare. So before you get too rhapsodic about restore and rediscovery, we really don't want to go back to those good old days.

Then, you know, the dust would settle. Everybody's outrage, you know, would calm down. And then we would say to each other, "Okay. So our task is to invent professionalism. If we can't restore it, we should invent it."

But that was, again, a kind of frame that could not exist for very long. Everybody in this room and everybody in that room knows it well. The Hippocratic Oath dates back and, you know, if you want to bring a laugh to a medical audience, all you have to say is, there is no Hippocratic Oath for lawyers. It's the medical students at commencements who recite, not the business school students. You know the rest of that litany. And it's a powerful document, obviously amended by almost all of the medical schools that use it.

But the key values — confidentiality, do no harm, respect for the body of the patient even if the body of the patient — you'll remember that line — is the body of a slave. I mean, that's startling in its way.

So, I mean, invent when you have that kind of tradition?

And medicine as we do know and we recognize had a long tradition of serving the under-privileged. In pre-Medicare/Medicaid days, there was a Robin Hood quality about medical practice. Well-to-do patients paid more. Poorer patients paid less. And many physicians to this day serve patients' well-being impervious to the clock, the day of the week, the nature of the holiday. So "invent" seemed, if you will, totally presumptuous.

We went round and round this cycle of revive/ invent several times, and we soon recognized that the internal debate we were having matched up quite well with the academic debate that had gone on within the history and sociology of medicine over now almost the past 90 years.

In the 1930s, the major frame or analytic context for understanding medical professionalism was the work of Talcott Parsons, a famous sociologist. I suspect some of you have read him as well. Parsons

treated medicine as the quintessential profession. This profession, he argued, had a collective orientation, and he very, very clearly contrasted it to business, which was self-interested.

For Parsons, the financial self-interest that business characterized as normative was outlawed in ethics and the practice of medicine. He was altogether confident in declaring that patients should put themselves in doctor's hands, do as they were told, commit themselves to recovering. No patient activism there. You listened to your doctor. You did as your doctor told you.

Parsons did all his field work at Mass General. A very sophisticated sociologist, he had no trouble thinking that Massachusetts General, MGH, represented the world of medicine. Startling as we read him but very, very much there, professionalism in his context and his influence, I think you appreciate. Professionalism, doctors serving patients' best interest, was the hallmark of the field.

But in the 1950s and 1960s, a very different line of interpretation comes to dominate this territory. Professionalism now becomes the synonym for guild monopoly. Restrictions on entry to the profession, exams, licensing, these are not intended to maintain quality, the school argued, but to restrict the number of practitioners. And why restrict them? Obviously, so that those already inside would be able to protect and raise their incomes.

Self-regulation was a sham, variations on the fox guarding the chicken coop. Physicians in this school had only one goal: Protect their own and advance their own financial interests.

Well, those two rival schools, if you will, one succeeding the other, as you look at this over the past 10, 15 years, the wheel of interpretation has turned again, not all the way back to Parsons but quite close.

Professionalism now has become the best hope for resisting the demands of managed care or any profit-seeking managers and auditors. The patient is to be represented and stood up for by the doctor. Indeed, because the government was not only *a* payer but *the* payer, professionalism had to resist its intrusions as well. And as I think everybody in this room recognizes, we've had a fabulously intense revival of professionalism, and we are almost back in the days of Parsons.

So two important findings. I think I want to draw your attention to this little anecdotal survey: One, there is no single historical line of interpretation that will resolve the question of whether past crises are more severe than current ones. You know, whichever frame you prefer you may adopt, you can emphasize, you can stress. But there is no one line of interpretation that will enable you to say "Back then, it was so good. Now, it is ... don't go down that road, I would urge you." There is really no way of saying whether the profession has deteriorated in its performance, whether doctors are or are not less committed.

Second, in the case of my own organization, we found ourselves, after we went round the wheel abandoning the issue, trying not to resolve the past record, but defining ourselves in terms of future action. We take as our fundamental challenge, leaving aside this historical context that I provided you with, our fundamental challenge: What is the role for professionalism in the 21st Century? Going forward, what does it mean to make professionalism a force for change?

Clearly, the practice of medicine is different today than it was 50 years ago. It's different in what it can do. It's different in what it should do in terms of best practices, fundamental differences in who does it, differences in practice conditions, and differences in reimbursements.

The assignment then becomes, given these changes, what do we do to enhance, promote, use professionalism as the guide for action? What considerations, whether in medical education — which you'll hear from later today — in medical practice, in physician's behavior, in health policy, what difference should professionalism make? And in the time I have with you this morning, I'd like to begin to suggest some answers to that question.

I've avoided until now, but it's not a serious issue, the definition of what we mean by professionalism. Perhaps surprisingly, although not in a room like this, there's a good deal of agreement on just what its attributes are: Altruism and commitment to patients' interests, the starting point for everyone; profession as self-regulating, clear to everyone; the obligation to maintain technical competence, again clear to everyone; civic engagement, which I'll only say a word or two about in a moment, a little bit more controversial. But there are those of us, and I think you've heard from them, too, over the past several years who would put civic engagement in there as one of the attributes of the profession.

I'm going to come back to the key altruism point. But I want to begin with the others because the altruism and commitment to patients' interests is so important and so complicated, if we begin

there, I'm afraid we won't get out.

Professionalism's commitment to self-regulation. The historical record is weak. If I was going to [be] more aggressive, I could say pitiful.

The tradition of passing on troublesome colleagues to the next institution. Every major institution that I know of and have been affiliated with is totally scrupulous in terms of who gets to practice medicine under its umbrella. I mean, you know, I know this. I experience it. And if there are lesser physicians in terms of talent, etcetera, etcetera, you know, a friend is going to go there, I will be told immediately, "Uh-uh, not there. You go here. Thank you."

As institutions, we are terrific at monitoring the capacity and quality of our fellow practitioners. The problem though is that our loyalties are very institution-bound, and we have no difficulty often in passing on colleagues that we would not send our relatives to to the next institution. Periodically, scandals will break out, and New York has had its share. We don't do a very good job outside of our own turf.

Failure to police activities. We just came off a fabulous scam in whole-body scans. Right? I mean, a useless, expensive, anything-but-evidence-based procedure, although it collects a good — collected, I'm happy I can use the past tense. I mean, obviously the major professional societies did, you know, in the radiology world say "uh-uh." But very, very little concerted action taken to really put an end to this. I mean, you know, let a scam come up. You don't see a lot of organized action to take it down.

Anti-aging clinics, cosmetic claims, the anti-aging claims. Manhattan has several. I'm sure Florida, Arizona, California beat us by the many. It is a scam. Many of us in this room have a real stake in anti-aging claims would that they were valid. But I think most of us in this room would suggest that giving 75-year-old men heavy doses of testosterone might not be the thing you want to do. And we've learned, despite all the complexity, etcetera, etcetera, giving 65-year-old women estrogen is not the thing to do. Growth hormone — I mean, you know the litany.

And yet you can walk on the East Side of Manhattan as well as in these other states, and there they are. There's even now an anti-aging [specialty] — I don't know. I think they call themselves that. It's not recognized by the G and E [graduate medical education] world. But there it is in medicine's record, so to speak, and taking these things down is not very great.

Maintenance of technical competence, reducing medical error. There the profession has done a more credible job. But the challenges it faces are going to be quite extraordinary. The chart which was once thought of as, if you will, in private practice belonging to the doc, if not, in institutions, making the chart transparent, the use of information technology; sharing data, somebody looking over your shoulder; recertification — I think many of you in the room will know the stories of what happened of when the ABIM tried to put in recertification — resistance, but it may yet come through. The younger generation is perfectly comfortable with it; and the evidence-based medicine debates, which are quite fierce.

I've just finished reviewing Jerome Groopman's book [*How Doctors Think*]. The reviews didn't talk about this, but I certainly do. It's a polemic in a variety of ways against evidence-based medicine. It's going to ruin the clinical intuition, and he comes out very, very strongly against it. He was worrying about clinical insight. Many others, of course, worry about the failure to do what ought to be done, whether it's the use of beta-blockers or, you know, other interventions. A major area, and one I think that's going to see enormous amount of activity.

I won't spend much time on civic engagement except that the data is overwhelming that physicians do not participate in community affairs, and I'm allowed to say, even pediatricians who lead the pack don't lead it by a lot.

You don't find physicians participating often in public discussions. It's a much more reclusive profession except for many of its professional medical associations. But most of them spend their lobbying money on protecting members' interests. They are member-interest driven rather than advocating for the public good. This is not always true. Pediatrics, some of the medicine groups can escape it.

In the New England Journal of Medicine piece that is in your packet, I said something which brought me more shouts and screams than most things that I say. I was dealing with this question of advocating for more than pocketbook interests. And there's a quip in there, "would that ophthalmologists rather than GI guys advocated for colonoscopy." Well, I mean, I meant it in just this frame. You can't imagine the invective that I got. Don't you know the difference between an eye — you know, you can fill in the rest.

I was tempted to remind some of my writers that ophthalmologists to the best of my knowledge had received MD degrees and might be perfectly competent to review colonoscopy-funding decisions. But what I was trying to do was to get out of the box. It was not a particularly well-appreciated line.

Let's come to the core issue, altruism and commitment to patients' interests: money versus medicine, the HMO/hospital/group practice/financial incentives, the drug company gifts and payments. I mean, I've already given you a frame that says it ain't quite as new as some of those who worry about this may believe, but it is certainly hot on the public agenda.

I use this slide for a purpose, and it's not simply to wake up a sleepy audience, which is not this. A physician: "Try this. I just bought a hundred shares." All right, now this appeared in The New Yorker about a year and a half ago if I remember. I don't want to spend a lot of time deconstructing it. But just do the thought process of the presumptions among those who edit The New Yorker and its readers, you know, that this will be understood, will be seen as funny. This builds on a lot of assumptions that suggest that ultimately the professional is really money-driven. Parsons notwithstanding, this is what it's about. That this is seen as understandable and humorous suggests a quite jaded public view of exactly what's going on.

This slide comes from The New York Times as you see. On the weekend, she's a cheerleader. During the week, she's a drug rep. When I'm lecturing the medical students, I remind them that once upon a time in the '60s and '70s — Dr. Pellegrino will probably agree — the anatomy course would, you know, throw in pictures like this even a little racier to wake up students. Now we're at '05.

And, again, what does this say about the profession to the public?

I will share quickly a humorous story. I had been doing some work in China on issues of professionalism. They were interested in it for a variety of reasons, and I sent this slide. And then I had some second thoughts about it, did I really want a Chinese audience to deal with this? And I wrote to the convener of the meeting and said, "Look, take that slide out." And he e-mailed me back very quickly, "Yes. We will take this slide out and we're delighted that you made this decision. Our translators couldn't figure out what a postage-stamp skirt was," the dangers of doing cross-cultural work.

(Laughter.)

The press coverage. For a project that I'll tell you a little bit about later, we had one of our researchers just cover the press, you know, over July, the extent of it, a lot of it in The Times, a lot of it in The Journal. But it goes out to The San Jose Mercury News, "Science critics ... Financial Ties", "Financial Ties to Industry ...", "Hospital Chiefs Get Paid for Advice on Selling to Hospitals," "Indictment of Doctor Tests Drug Marketing Rules." I mean, again, it goes on, "... Conflicted Medical Journals." Look, this is the reading public. A week? You know, I keep a pretty extensive file. There can't be a week when I don't add to it on conflict of interest, and it's almost every day between The Wall Street Journal, The New York Times, The L.A. Times, The Philadelphia Inquirer.

Many of these reporters, by the way, are not in the health section but in the business section. So the public is getting a pretty steady accounting of conflict of interest, and it's very, very much on the public mind.

It was knowing this that the ABIM Foundation, at that point in time headed by Harry Kimball, and my organization got together to see what we might want to say about conflict of interest questions given their extraordinary prominence. In the room is one of my colleagues who worked on this, Susan Chimonas. You'll be hearing later from Jordy Cohen. You know many of the other names on here from Troy Brennan to Neil Smelser, Jerry Kassirer. I mean, you know these people.

We spent several years, two to three, doing this piece and found our task — well, we found two things. One, we had to create, so to speak, a table of contents which I'll show you in a moment. What were the major issues that ought to be on the table? And simultaneously we really tried to give an account of what we thought should be done. You know, what are our recommendations to deal with these issues?

I will say here that the group began very moderate in its posture. Given my training, I would call them, if you will, moderate abolitionists, gradual abolitionists, don't move too fast.

The more the group stayed with the issue and the more the analysis went on both in terms of information about the practice, the impacts of these various practices and our own sense of what should be done, we became, if you will, Garrisonians, immediate abolitionists.

And this is a fairly consistent, if you will, abolition document. It's had, I mean from our perspective, a wonderful more neutrally-put extensive impact, maybe even more because we set out the table of contents in the left-hand column, the activity that, you know, we worried about. I mean, the left-hand column has now become, if you will, the checklist as more and more institutions review their own policies on conflict of interest.

We limited ourselves incidentally to academic medical centers because we could find no easy way to influence community physicians. That seemed beyond us. But at least academic medical centers, centers which did all the training, centers of influence, there we could speak to them.

Gifts, meals — eliminate. You can read this. Samples — indirect, not in the doctor's office. Speakers' bureaus and ghostwriting — I mean, scandalous. The ghostwriting, it's hard to imagine anybody accepting this. This is what we throw kids out of college for. I mean, where we come from, it's plagiarism or something of that sort.

Speakers' bureaus — we're not talking about honoraria. That's a separate list. We're talking about joining the speakers' bureaus and becoming the hired hand of the drug company — skill, commercial sex work, I don't know what terms you want to use — infamous. And there we had no problem saying eliminate.

Payments — okay, but get it out of direct support for CME, get it out. Don't let the division chief or the chairman pick up the phone to call the drug company to say, "I need \$20,000 for...", that sort of thing.

Consulting, honoraria, and research contracts — we did not say no. I mean, we recognize fully well that, if you will, pharmaceutical companies are not tobacco companies. We appreciate that. You can't end all the nature of the relationship. And the cheap shots that were taken at us were, "You're demonizing the pharmaceutical company." We're not trying to demonize the pharmaceutical company. We were trying to eliminate as far as we could conflict of interest in this arena.

Consulting, speaking honoraria, and research contracts have to be maintained. But we do ask for transparency, but real transparency. Specify the terms of the service, make them available for public inspection, let it be known how much. You know, you'll see the disclosures in journals. Consultant to X drug company — \$100, \$500, or \$500,000? It does make a difference, and that urge on our part to render it transparent we think is crucial.

Formulary and other purchasing decisions — decision-makers must be conflict-free.

After the appearance of that article, I received a phone call from Pew Charitable Trusts who read the piece, saw the press coverage of it which was extensive, and then asked an embarrassing question: What did your committee think to do the week after the report was released?

Our committee in truth, as I told them, had not spent five minutes on what we would do after the release. Here's our view, but, I mean, we spent not a moment on what we might think about in terms of implementation. Pew Charitable Trusts is many things, but it's not the IRS. So when it says, "Think about it, and we'll help you," we were prepared to start thinking about it and we did.

The prescription project, funded handsomely by Pew, is working in a variety of areas, the two areas most central to our conversation today and really most central to the project, to see what we can do to change conflict of interest policies at academic medical centers.

There are some lead groups out there: Stanford, Yale, Penn — you'll read tomorrow about BU — Wisconsin, Michigan, Kaiser. It means a lot of forward action. The wind is to our back and we'll see what we can do in that territory — translate prescriptions into practice and the very same thing with professional medical societies.

I give you this and tell you this background to it because you are obviously quintessentially in the formulation area. It was unusual for us — we were not prepared for it — but we are finding it very exciting to look at actually changing practice in an area that we have been studying.

Where do we go from here? I worry. I worry a lot about "professionalism lite." I hear a lot about this. I get anxious when professionalism gets equated or swallowed up by good manners. Look, good manners are very, very important. I don't want to discount them in people or in doctors. But that's not the sum and substance of professionalism.

Humanism is important. Look, I come out of the social sciences and humanities, not out of medicine. And, you know, the humanistic spirit, god knows, is important. Again, I don't want to —

you know, I think it's important that medical students read literature, although I will tell you as you already know and can remember, there are professors of literature that I would no more trust to be good-mannered or acting in my best interest than anybody else. But humanism is important, but they are not substitutes for substance.

My last slide is probably my most controversial slide. Professionalism lite is easy to put down. At least, I think it's easy. I think it's really important to talk about what it really means to advocate for professionalism.

Put patients' interests first, but don't coddle that. That really is meaningful. Look, you may have to take a financial hit. That's what it may mean. You know, speakers' bureaus are fabulous. They'll send you to Hawaii and they'll pay you X-teen thousand.

One dean has mentioned to me that as he put in a ban on this sort of activity an angry colleague came up to him and said, "You are now depriving my children of their college education." Okay? I mean, rhetoric, not rhetoric? I don't know. But you certainly can get the heat up. If you mean it, this is what it means. You know, if you're really going to talk about it, this is what it means.

Technical competence? Sure. But it means you're going to have to let people look over your shoulder. None of us like having people look over our shoulder. That's not the most pleasant activity, but that's what it really means.

Self-regulation. You're going to have to say something. From my context, you know, the guy who is handing out testosterone, you know, like it's life-savers, do something. Report a colleague. It's not comfortable. None of these is comfortable. But ultimately I think they're crucial.

The last slide, you know, the last bullet, physicians will campaign for public benefits, not private reimbursement. Change the orientation of professional societies. Members may not like it, but that may simply make the issues all the more important.

Thank you for listening. I've enjoyed the chance to present, and I look forward to the discussion.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Rothman. Dr. Dan Foster, a member of the Council, has graciously agreed to open the discussion. Dan?

DR. FOSTER: I didn't really agree. I was just told to do it.

(Laughter.)

CHAIRMAN PELLEGRINO: But you were told graciously.

DR. FOSTER: Well, I think that, I mean, there are many things that one could comment on in the report and very little that I think that I would disagree with.

The first comment I want to make is that the good old days of all-white males are completely gone in most academic centers, I'm sure. I was at Columbia not too long ago. White males are an endangered species in medicine. We have 55 new interns and four are white men. I mean, it goes back.

There are no, almost no, white males going into medicine anymore and for complicated reasons. There are many women and, of course, a huge number are of second-generation persons from Oriental and other [ethnic backgrounds]. But that one, we don't have to worry about anymore.

Secondly, the traditional views of professionalism, as you pointed out, go back a very long time and were much narrower than the social issues that you have talked about here.

Osler in 1902 gave a great talk in which he started off — he had four things to say about medicine and what it should be. He said it had a noble heritage, that there was a long line of true physicians that went back to the founders like Maimonides and Hippocrates and so forth, and that he was asking the guild, as he called it at the time, to take their place at the end of this long noble line. He believed that it was a noble profession.

And if you go back and read the history, that term "noble" enters very often.

Secondly, he said that it had a remarkable solidarity to track to their sources the causes of disease and to make these new findings available to everyone. It was not a solidarity of race or sex or political meaning. It was to fight disease. It was to prevent premature death and cure disease when that was possible, that it was to alleviate symptoms when cure was not possible. It was to comfort

always, the priestly function.

Third, he said it had a progressive character. In his day, they were shifting from magic to science, and they did it. They made that change. That meant that one was a life student. It has to do with your issue of technical competence, which is not easy. I'll comment in just a second.

And, finally, he said, it had a singular beneficence. He said the relief of human suffering was such to make the angels sing. We don't talk like that anymore. But this was the core of professionalism in Osler's view, and I think that still holds very much.

The technical issues are not solved by evidence-based medicine. One of the real problems is that you have very good studies by very good people who come to different conclusions. For a long time, we believed that estrogen replacement would be helpful in terms of heart failure and so forth in women. Everybody agrees that this was a solid statistically-wonderful study, and then it changes. And they change in different parts of the country, so it's not — and then you worry about a challenge to the nature of journals that 35 percent of their statistical analyses were no good and they didn't believe it, and they reproduced this from the Spanish statisticians that challenged it, and it turned out it was true.

So oftentimes the — and the meta-analyses that everybody pays attention to about, you know, whether this — I think most scientists are really skeptical about that because you don't know. You're giving equal comment to studies of all sorts of things, old people versus young people, all sorts of things of that sort, so it's a problem.

And then in the traditional sense, Joe Goldstein in his last career award — I can't remember whether I mentioned this before sometime. But in 2004 — and I didn't check it — there were 550,000 papers published in the biomedical literature in the 4,000 journals that the National Library of Medicine archives in PubMed and so forth.

550,000 — that's more than a paper a minute. Now let's say that only one of 1,000, Goldstein said, if only 1 of 1,000 is important, that's still 500 major papers that a practitioner and a scientist has to keep up with to do it, and that has nothing to do with this issue of somebody looking over and what best practices are. It's much more complicated than that, I think, and much more difficult than to be dedicated to try to learn those things.

And I think the last thing that I want to say is that it's very easy to recommend to others that their income ought to go down. As Bud Relman said last week, "You can't go to any major city in the country and find an internist for an aging patient." People won't take Medicare anymore. They don't follow their Medicare patients, because their income goes down.

I have a son who is a general internist, and he's very good. He admits his own patients to Baylor Hospital and so forth, and he has a wonderful group. His income has gone down every year for the last four years. And he doesn't do anything shady. I mean, he doesn't give Botox or anything like that.

But I'm not talking about big money. I mean, there are some people that make big money. I'm talking about trying to make \$100,000 a year as a general internist. I get \$40 for seeing them. I'm a professor, but I get \$40 for seeing a patient for Medicare. We still see them... Internists are very demoralized these days because of these changes in money and so forth and the fact that it goes on here. And we had taken our dog to the veterinarian, two dogs we took for a bath and shots. And it was \$250 cash upfront. And I get paid months later \$40 for seeing a patient.

So there's a worry about that. And then to say, "Well, you're going to have to take a hit financially if you're honorable" — that's sort of what it says. And that's probably true.

But that's very easy to say when you're not — and I'm not speaking about you at all, you understand. But it's very hard to find people to even go into general internal medicine anymore to get people who will take care of real patients, not subspecialty.

And the last thing I would say is that I don't think — I know you're not attacking drug companies. But almost everything that happens, one has to look for somebody who must have some interest to give significant money.

I'm the president of the Academy of Medicine, Engineering, and Science in Texas. That's all the people who are members of the national academies that live in Texas. And in response to the gathering storm report of the National Academy about the failure of their — there's a great editorial in Science this week about stem and so forth.

But we took on at the request of Senator Kay Bailey Hutchinson, our senior senator, the Academy is going to study the teaching of math, science, and technology in the Texas schools. This academy has no money, I mean, really. I mean, the university presidents give us about \$250,000 total a year, you know, to keep up with.

So we have to say, this is a very great thing to do. How are you going to do it? Well, the first gift we got was from Dow Chemical. They didn't put any [conditions] — they just said, "We're very interested in this" and so forth. But everything that you want to try to do, you have to have somebody that's got some sort of an interest unless they're purely altruistic that they just want to give money. And the pressure from their stockholders is very hard, you know, if you're going to give a lot of money to support the study of Texas schools.

So, I guess I'm a little worried about the idea that the involvement of big businesses and so forth has to be always completely pure without any interest. I mean, nobody in the government does anything without some interest that they have, and I think we have to be careful about the terrible things that your group on professionalism has said.

But I think it's going to be a little hard to say, "Well, we can't receive." There's always an implication that nobody gives money unless they have a self-interest. Well, if you give money to the symphony in Dallas, you have a self-interest because people will think American Airlines is good if that do that and so forth. But, anyway, I think it's a terrific thing here.

The last thing I would say is that I think it's hard to teach ethics or to teach professionalism by papers or by lectures. There's a statement that I gave that I found that I thought was very interesting, and it was about the contract between teachers and students, what do they owe each other? This person who writes about this a lot said, "Great teachers don't teach. They help students to learn." That's a profound statement. "Great teachers do not give lectures," he says. "Great teachers do not teach. They help students to learn."

It seems to me most of the time the lessons of individual professionalisms of the Osler type and so forth almost always occur because of a role-model who is professional and where they see.

So I'm fairly skeptical about the — I think it's good to get a structure of what ethics means and so forth, and probably somebody should have a lecture of that. But I don't think we're going to transform people to working in the public interest and so forth, let's say, for health unless there are people who do it that a student can identify with. So I'm not sure that one can teach in a didactic sense what professionalism is about.

So I think this is a wonderful effort that one has made. But I think that one has to be — and maybe the prescription thing is an excellent way to go. I mean, I don't know. But I think it's really, really hard, and I wouldn't want to think that it's a simple thing to deal with, and I know that you don't think that because you do this all the time. I don't do it at all, but, I mean, except that — I would say I don't want to sound self-serving. But I do try to show it, you know, on the wards and so forth.

And I've been very active in public. I ran for the Presbyterian Church all the inner-city work for four years in Dallas, Texas. I've been involved in all these things, so I'm not being critical about it. But you have to be motivated to want to do that, I mean.

I rented the Dallas Auditorium for the first Martin Luther King celebration without permission from the Church. I thought I was going to get ex-communicated, but they actually thought it was a nice thing to do. So you just have to have a model. I served on the Dallas School Board. I was a trustee during the desegregation case. But you have to have somebody who does this that says, "Well, maybe I could do this."

And the last thing I'd say, I'm very touched by the AIDS work that a drug company is sponsoring in South Africa and Africa where all these young physicians — I think there are 50 or 60 now — that are sent there for two years. I have a bunch, a number, that are over there. They are paying their salaries. They're building the clinics. And these young people, these young people where they're right in the middle of their careers, you know, that haven't finished their fellowships and so forth, are giving two years of their — and so you see these sorts of things. Now they're an inspiration to me to do that.

I didn't mean to talk so long about this, but it's something that I feel very strongly about. And as I say, I think that it's going to be hard to universalize this and I think it's going to be awfully hard to get people to say, "Well, I'm going to cut my salary" when nobody else does it. I think that's going to be hard.

CHAIRMAN PELLEGRINO: Thank you very much, Dan. Dr. Rothman, did you want to make a brief —

PROF. ROTHMAN: I think it would be more helpful to hear the others.

CHAIRMAN PELLEGRINO: Very good. Thank you.

DR. CARSON: I identify very, very strongly with Dan's comments. They're right on target. You know, I've spent my entire career in academic medicine where there has not been as much of a drive to enhance one's income. Sort of automatically, one takes the altruistic road when one decides to go into academic medicine. Nevertheless, those people that do still have pressures.

I'm reminded of the story of the neurosurgeon who had some plumbing work done at his house and the plumber gave him the bill, and it was \$2700. He said, "\$2700? I'm a neurosurgeon. I don't make that much," and the plumber said, "I didn't make that much either when I was a neurosurgeon."

(Laughter.)

But, you know, the fact of the matter is that there always has been sort of this feeling that doctors make too much money. It may even stem back from when people were in grade school. You know, people who went on to become doctors were always the ones who sort of changed the curve and made you get a bad grade and, you know, people feel resentful of those kinds of individuals.

But one has to take into consideration the enormous amount of money that it takes to pursue a medical career. I was talking to a fourth-year student not long ago, a medical student. I said, "What's your debt up to?" He said, "\$300,000," you know, when you still have internship and residency to go through and you're not going to be paid very much money during that time and all of your friends who have gotten their MBAs and their legal degrees are, you know, leagues ahead of you, and then you get into the profession and people say, "You shouldn't make any money. You should be a good guy," you know, that doesn't compute.

So, you know, we need to actually address those issues rather than just, you know, making little platitudinous statements about you guys ought to not really be interested in a financial remuneration.

CHAIRMAN PELLEGRINO: I have Dr. Hurlbut and Dr. Meilaender after him.

DR. HURLBUT: So you articulated certain dimensions of the problem well, but I want to explore something that's implicit in what you were saying.

In the first comment you made, you spoke of the dominant culture that governed medicine in the past, and it wasn't really the good old days only. I mean, obviously if the physicians are all male, white, and upper-middle class it indicates a lack of opportunity for some people, but also perhaps more seriously a kind of limited perspective engaged in the practice of medicine, a kind of prevailing culture.

And so basically what I want to ask you is, what limitations are subtly and maybe unconsciously being imposed by today's prevailing culture? And just to unpack that a little, we are, at least by some critics, a materialistic consumer-driven society. Maybe that's influencing physician's values and their codes of conduct and self-justifications as you've said.

But could it also be that there are some other dimensions? You mentioned enhancement technologies. Without really giving much articulation to it, you dismissed some practices that physicians do as being not physicianly.

So what I'd just like to get at is, what do you think the role of the physician really is? What are our purposes? What are the limits of our prerogative? And what kind of service are you really calling us to be?

And I know that's a very big question and very broad, but just if you could make some comments about what dimensions of the prevailing culture might be perverting medicine today and how we might more specifically articulate the professional role in the face of those.

PROF. ROTHMAN: I know I promised Dr. Pellegrino that I wouldn't comment until all, but your question is so specific so I'll address it. It's a truly wonderful question. I won't comment on the first part of it, but I promise you the next time I get to talk about that I will.

What did it mean? What did it mean that it was an all-male, all-white, upper-middle class profession? That's a great question. And there are things that it did mean, but we'll save that for another time given the limits of time here.

But your second question — and it's actually helpful given the comments, you know, that came before you. I'll give two examples. Remember in the old days, you know, in the rationing debate when Oregon did its rationing scheme and it limited it to, you know, Medicaid patients, many of us said, "When it comes to rationing, it's really easy to ration the other guy's medical care." Right? I can tomorrow ration Medicaid. Right? But, you know, if you're going to start rationing my medical care, etcetera, etcetera.

And I was not intending to have physicians take a vow of poverty. You know, that's not my theme, and your question enables it. What do you think the problems are? I'll give you two examples from The New York Times — but then please respond back — a story within the past week.

It will take you approximately — don't hold me to the exact numbers. It will take you 30 days to get a dermatologist, the Times wrote, to take off a suspicious-looking wart to see if that wart is cancerous. It will take you four days to get Botox. Okay? Something's wrong.

Now this is not a vow of poverty, and I'm not trying to do a number on dermatologists. But there's something going on that you can get your Botox — and we know what's going on. Dr. Foster, your comments. You think it's hard to get into medical school? Try to get your kids into veterinary school. I mean, the word is out. I mean, you know, people understand this. The plumbers aren't lining up quite so much. That's humor. It's not real. But the vets are real. So a profession in which you get Botox quicker than you can get a biopsy.

A story about a year ago of a guy coming out of oncology who self-reported, you know, was making \$300,000 or \$400,000 goes to Goldman Sachs, works for Goldman Sachs and now is making, you know, \$3,000,000 to \$5,000,000, I mean, and was quite proud of it, by the by, and when asked whether he felt any twinges, etcetera, etcetera, he said, "No. Sooner rather than later I'll become a philanthropist."

So the question is, you know, it's not a vow of poverty. Nobody intended that, although I will also just add parenthetically until the middle '60s the profession was not particularly well-paid. Then procedures and Medicare came in and changed the income distribution, procedures particularly by detaching reimbursement from time. That's really another subject.

But it's a profession. And the meaning of the profession taught, modeled — I have no problems with that — somehow or another communicated. Jordy Cohen will be talking about medical education in a little bit.

You know, Botox is really neat. But, you know, biopsy first. That kind of message. I'm not saying — you know, if you want to run a little thing on the side to make some money, all right. But don't bump biopsy for Botox. It's like a car sticker. Right? Don't bump biopsies for Botox, somehow or other by modeling, by freeing medicine up from the more obviously marketing ploys, from trying to give a sense of value that this is not a marketplace activity.

But please respond back.

DR. FOSTER: Let me just make one comment in the Botox thing. What's wrong with that article is that the Botox is done by technicians and not by the doctor, and so it's very easy for them to just schedule somebody to come in. You know, you don't even have to be an MD to give Botox. At least in Texas, you don't.

So I think one of the problems is that you have a physician assistant or somebody who can do things faster and that may be one of the reasons. I'm sure it's money. Don't misunderstand.

PROF. ROTHMAN: The Times piece didn't draw that distinction. I don't know if it was in their story.

DR. HURLBUT: What I'm really getting at is — I mean, you've partly answered this — what you might call prevailing cultural values. They're almost unconscious to the culture. It's so close to you that you can't see it.

PROF. ROTHMAN: Yes, yes.

DR. HURLBUT: And here I'm thinking of things like the emphasis on autonomy and individuality

that prevails in our culture, the sense that there's a new relationship, not patient/doctor but client/provider, where we're serving the patient's aspirations and ambitions and not necessarily more profoundly articulated purposes and values.

Just to give two very obvious and extreme examples, physicians have been expected to become executioners at death penalties and in some cases implicitly expected to serve patients' personal desires for gender-selection abortions. And so I'd like you to comment a little on this.

These are worrisome things because if the physician's role is socially-constructed and socially-defined, then are we somehow in need of a deeper root, both intellectually and specifically articulated in our code of conduct?

It seems to me that physicians are in danger of becoming agents, not just of individual patient's desires, but of larger unarticulated purposes of the society as a whole including almost becoming tacit social scientists and engineers for the kind of society that we want to get and, strangely, even ultimate authorities on matters of what defines personal responsibility, what defines acceptable species' conduct, what even defines human purpose.

These are really new roles for the physician, it seems to me, and it seems a lot of this is very unconscious. A lot of it is just our not being aware enough of how we as a society are actually imposing certain values onto medicine itself.

PROF. ROTHMAN: But then — and just a response, because there's so much more, but these are fabulous points.

I taught a couple of years ago with a colleague in the law school. We taught a course to law students and medical students. And I don't mean this as a putdown of lawyers. The lawyers really define themselves as client-driven. Hired guns is not, you know, etcetera, etcetera. The medical students to their credit were much, much more conscious — I mean, they could go overboard, too — much more conscious of the fact that, although they had duties, they also had professional obligations.

I mean, the gorgeous case that you raised: The AMA to its credit and others not allowing for the physician participation in capital punishment. It's a very — I mean, that was well-done. You are not the handmaiden of the criminal justice system. The criminal justice system may decide to do capital punishment. You, as physicians, don't belong there. And that was done and said very, very well. You're not the hired guns.

I mean, yes, I know. And this notion of physician-patient partnership, I have a lot of difficulty with that. I mean, I didn't go to medical school. I hope my doctor went to medical school. I don't want to deal with all the stuff that he knows. I don't have to find that out. It's a complicated relationship.

But you're not a hired gun, and I think that has another aspect of professionalism. Indeed, it's what, you know, I think in many ways drove Soros and others to say, "The state doesn't control you." The government says, you know, a gag rule on abortion discussions. Medicine got its back up. We're not here to take orders on what we say to our patients. We're not here to be servants in your criminal justice system. We have an ethic and an ethos apart from the society.

Now it's tricky and hard to teach it, and it's tricky and hard to model it. But you're really at what I think are core issues of professionalism.

CHAIRMAN PELLEGRINO: We have Dr. Meilaender, Dr. Dresser, Dr. Kass, and Dr. George. And before you launch into your comments, thank you. We'll start with Dr. Meilaender.

PROF. MEILAENDER: Yes. I'm not sure whether this is a question or a comment, but I've been trying to think about sort of what a body like this is to make of your presentation.

And for me at least, I'm more persuaded by certain examples. That is to say, when you're lower to the ground and you give an example of a particular conflict of interest or something, I'm more persuaded by that than by the theory of professionalism which seems to me to need — I don't know — to need work in a lot of ways.

I'll just tick them off. I won't try to defend them at length right now.

But it's not clear to me why a professional, simply because he or she is a professional, is to be civically engaged. There may be other reasons why they should, but. Nor is it clear to me why I should pay particular attention to them when they're civically engaged just because they have professional expertise. That's one sort of thing.

Second, putting patient interest first — and this relates to Bill Hurlbut's comment — I mean, this needs a lot of sorting out. By patient interest, do we mean patient's desires? Do we mean the good of the patient? The health of the patient? Patient interest covers a whole range of sorts of things there and, in fact, blurs some important arguments that it seems to me need to be made.

And then third, and sort of most importantly and most central to your presentation on the issue of altruism — I mean, Dan Foster said everybody has interests. I think that's true. We need a lot more work on what we mean by "altruism" if this is to be theoretically helpful, it seems to me. You don't want people who lack interests. That would be to lack projects in life, sort of. Nor is it necessarily a bad thing if my interest and the interest of the others should coincide in various ways. I mean, this is not a bad thing.

So whatever altruism means, it doesn't mean the obliteration of self-interest, at least I'd like to see the theory worked out that persuasively argued that. I doubt if it can be done.

So at the theoretical level, it seems to me — I'm just not sure — I'm not entirely persuaded and I'm not sure kind of where to go though a lot of your particular examples seem to me, you know, fairly persuasive.

CHAIRMAN PELLEGRINO: Dr. Dresser?

PROF. DRESSER: Thank you. I really liked the JAMA article because it went beyond hand-wringing and really some, I think, concrete and reasonable recommendations.

I wondered if you had thought much about the internal challenges in academic medicine to being a good professional. I see my colleagues at the medical school torn in a million directions. Should I spend more time teaching with students? Should I see more patients? Should I spend more time in the lab and on research and getting published?

And to me those conflicts really certainly affect patients and students and the contribution to knowledge.

So in some ways it seems to me at least the academic medical profession needs to think about, well, what does it mean to be an academic medical professional today? Is everyone supposed to do everything? Are there different classifications? Because it seems to me when I see so many people trying to do everything and they're suffering and the patients are suffering, I would hope that that could be a component of this work.

PROF. ROTHMAN: That's very interesting.

CHAIRMAN PELLEGRINO: Dr. Kass?

DR. KASS: Thank you. This picks up, I think things that Gil and, to some extent, Bill Hurlbut were saying.

I don't doubt for a moment the seriousness of the kinds of threats to medicine as a profession that you've identified here, but they mostly seem to be the temptations connected with money and have to do really with these external matters that tend to corrupt.

And it seems to me the emphasis on professionalism, which I find a distraction and not terribly helpful, quite frankly, gets to be defined as the opposite of the trade because the problem seems to be the corruption that the trade element introduces into what it is you think should be going on and, therefore, the language of interests as opposed to altruism seems to come out to the center.

Are you serving your own self-interests defined in terms of being a tradesman rather than the interests of your patients? And I think that's what sorts of skews the presentation.

I don't think Hippocrates would have understood himself as a professional. He would have understood himself as a healer. And it seems to me — I would be interested to know how one begins to think about the special aspects of that kind of professing which is the activity of healing and whether we worry slightly wrongly if we think simply about the deformations that occur at the margins and don't think enough about the positive definition of what it means to undertake the vocation of being a healer, and that's to begin really not with some abstract notions of profession and worry about the deformations and the misconduct, but to talk about the professional formation concretely in terms of what is this work, and we'll talk about it.

And Dr. Pellegrino's paper, I think for my money, comes a lot closer at least to those internal questions of the character of the profession, and I wonder whether you've thought about those things

which are internal to medicine having nothing to do with money that are every bit as much of a challenge to doing this work well as are these kinds of deformations.

Dan Foster landed on one of them simply talking about what it really means today to try to be technically competent. And a small piece of that also is a drive towards specialization which isn't simply money-driven, but it's very, very hard for anybody comprehensively to serve the patient's well-being in this kind of age when so much is needed.

And similarly with technology. I mean, we would not want to do without some of these things notwithstanding the fact that their abuses are commercially-driven.

So I'm really wondering about the presentation of the model of a healer in an age of hyper-specialization and massive increases of knowledge and to not let go of the fundamental meaning of what it is to reach a hand out and accept the reach for help on the part of someone who is ill and wants your loyal service.

PROF. ROTHMAN: A quick question back to you, although the Chairman is probably going to disallow it, but let me just do it very quickly.

There is a common ground. I mean, you know, how you deal with the practice, how you deal with competence given these articles and, you know, and the role, you know, given those numbers. That's been one of the things that the evidence-based crowd says.

My problem with "healer" is that it individualizes. The term itself seems to render the practice. It's not necessarily integral to it, but it, so to speak, turns it back one-to-one. And those of us who worry about the profession really want to think much, much more about — I hate to use this word and don't hold me to it much — the collective organized responsibilities that, in fact, the profession has responsibilities.

"Healer" seems to put it — and maybe you missed my reading of it, so it's really a question back to you. "Healer" seems to put it back in that kind of examine room one-on-one where those of us who are worried about the profession are really thinking about organized collective responsibilities, really as was being said. But you're smiling, so I think I may have touched something, but I'm not sure.

DR. KASS: Mr. Chairman, can I have 30 seconds? If it's out of order, tell me.

CHAIRMAN PELLEGRINO: No, go ahead.

DR. KASS: No. Look, I don't deny that there are systemic things from how medicine is paid for to how the professional societies organize themselves that are important.

But it seems to me that if one wants to form physicians who understand what it means to do the work, one has to really take absolutely seriously that their work is encountered one-by-one and these other things are constraints which sets the boundaries.

But how you model what it means to actually — I mean, Hippocrates says, "I will apply dietetic measures for the benefit of the sick. I will keep them from harm and injustice." And that's a kind of — that's a vocation. And without that, the rest of the stuff, it seems to me, can't do the work.

CHAIRMAN PELLEGRINO: Thanks, Leon. I have Professor George and I also have Dr. Carson, and then I think we'll give Dr. Rothman a chance to respond.

We're going to be discussing this subject this afternoon, and I think some of these questions will be recurrent and you'll have an opportunity to discuss them in more extent. So Robby?

PROF. GEORGE: Thank you, Ed.

Dr. Rothman, thank you for your presentation. I was impressed by your wonderful moral passion and by the almost prophetic stance that your organization takes toward holding physicians as professionals to very high moral standards. We can debate, you know, whether they're the right moral standards. But the idea, I gather, really is to hold people to high standards.

Now, of course, that presupposes that we can know something about morality. We can know something about the truth of these matters, about moral truth which, of course, raises the question, how do we know such things? And in questions of disputation among serious people, how do we decide whether it's a good thing or a bad thing for doctors, for example, to be involved in capital punishment?

Obviously, the decision has got to be made. It's a moral question. I think you're presupposing that we have some way of knowing these moral answers to these moral questions, so I'm kind of curious about where you and your organization come up with what you think the moral truth of the matter is.

Secondly, I'm impressed in the willingness of the organization, like advocacy organizations across the spectrum irrespective of ideology, right or left and so forth, to be willing to impose or see imposed on people adherence to these norms. They're not just putting them forward as optional. You want to see them imposed, like, for example, the norm that I gather you would like to see imposed that has been imposed that physicians may not participate in capital punishment.

So it's not just an ideal or a proposal to people. It's an imposition. And physicians who would dissent from this, who would want to make a few bucks or believe that they're doing a good thing and perhaps even something that justice requires in participating in capital punishment, they could lose their license to practice medicine or their standing if they deviated from this. So obviously you don't have a problem with norms, moral norms, being imposed on people.

But then where do we draw the line and why do we, why would you, for example, have a problem with the government telling physicians that, "Look, we don't want you promoting abortions. We think that's a bad thing, not a good thing. We've made a moral judgment. If you do that, you're violating what we think doctors ought to do, the moral norms doctors ought to stand up to"?

So obviously you don't think — you're not a hypocrite. You don't think it's all a question of whose ox is being gored. But how do you handle those admittedly very difficult questions when it comes to proposing the exercise of power to coerce people to conform to these norms?

CHAIRMAN PELLEGRINO: Thank you. Dr. Carson?

DR. CARSON: I want to thank Dr. Rothman for that wonderful presentation and for a willingness to try to take on such a big topic in such a small period of time.

PROF. ROTHMAN: I do get to teach a course, literally —

DR. CARSON: Basically, you need one.

PROF. ROTHMAN: — on professionalism. But that's a semester you've been spared.

DR. CARSON: You know, I wonder in academic medical centers where the breakdown of professionalism is in terms of individual clinicians versus administrations, when it comes to advancement in academics because, you know, having been in academic medicine for such a long time, I've seen an enormous number of absolutely top-notch clinicians, people who put patients first, who everybody absolutely loves, but they get the boot. Why? They haven't published enough papers. They haven't done enough research.

Have they fallen in down in their responsibility of professionalism or is it the academic institution and administrators?

CHAIRMAN PELLEGRINO: Thank you. Dr. Rothman?

PROF. ROTHMAN: Since there's so little time and I am between you and lunch, it's a relief that there's so little time. So to both you and Professor Dresser, Jordy Cohen is back there. He's going to have to take on these issues.

All I can tell you is that it ain't different at 168th Street than 116th Street where I come from. Oh, yes, we really want good teachers. And every ad hoc will, on promotion, say, "Oh, yes. We're really interested in teaching." I just can't remember the last time somebody who taught and didn't publish got a promotion.

And it's the same at the medical schools. At the medical schools it's times — look, since I went from 116th to 168th, I was stunned. I mean, you know, we had a first book for assistant professors, a second book for associate professor. And then I get up to the medical schools, and these — well, you know what that means, and they've started to change it — 97 articles of which he is first author on 69. You know, where are these numbers coming from? It was kind of unbelievable.

Now there are these — the majority I'm talking more about. There are these new positions of, you know, clinical educator and even Columbia which is a rather traditional place has adopted some of them.

But I think, you know, Dr. Cohen, you're going to take all this on later and deal with it.

The relief of time is to be able to avoid your question of the moral bases for doing this. The cop-out response is to say that in both of the instances that were raised, both capital punishment and the abortion, the profession itself rose to the position so that the question is really not so much directed at me. Although, do I have a problem with it? You know, no. But it's interesting.

It was the profession that took on the capital-punishment issue and responded, it thought — we won't have to parse out all the "it" — and it was the docs who were furious about the gag rule rather than it being, so to speak — it wasn't cases of me urging medicine to, although I would have, but I was irrelevant to this. The profession defined these as intrusive and violative.

Now, I mean, I'm sure there are some examples which I wouldn't be quite so happy — well, okay. The earlier ones that I used where the profession stood up and said, "We will not have government support of, you know, healthcare for the elderly," I mean that sort of thing.

But in those two cases that you raised, the profession did it.

I am not a philosopher and, you know, would probably not satisfy you even at my best as to why I thought both capital punishment and government intrusion into the examining room are inappropriate. I'd probably do better on the government-intrusion side. But, you know, I like the fact that the profession took on this stand. I mean, that spoke to its values, not my values.

PROF. GEORGE: But do you like it because of the outcome they reached? What if the medical profession would have said, as the medical profession once did, "Abortion is an evil thing. We do not want you involved in this. We will take your license away the way we will if you're involved in capital punishment"? Is it whose ox is being gored?

PROF. ROTHMAN: That's when we went to the courts. You're right. No, no. I'm with you all the way. It's horribly complicated, horribly complicated. And, look, this committee, you know, now we're really more on your turf than on mine thankfully. I mean, my line is "how nice," and I don't have the test case, although I did use the Medicare.

Let me just close with one last comment because I think I haven't given it — actually two comments which I haven't given justice to.

One, although we spoke mostly today and I spoke mostly today about the profession's obligation to itself, I equally and on other occasions have spoken at length about public policy's obligation to the profession, and that is serious and every bit as important.

The easiest example to use is payments systems. Sometimes when I talk about this at length I can talk about we really know how to raise a screwed-up kid. I mean, we know how to do that. You know, reward one thing one day, punish it the next. I mean, we can really teach you how to screw up your kid. How to raise a good kid is much more complicated.

We know how to set up a payment system that will be most subversive of professionalism. We witnessed this in managed care. Set a system up that rewards physicians absolutely to 70 percent of their salaries to the degree that they don't send patients on to specialists. I mean, we know how to do it badly.

The challenge: How does public policy treat the profession the way the profession should be treated? I mean, so don't hear me as only charging the profession. The issues of payment, for example, are infinitely complicated. But how do you pay professionals in ways that promote professionalism rather than subvert it — that kind of exercise?

The last point which we didn't get into although it's been intimated a little bit, and I just want to throw this out for your consideration and others will do it, and Dr. Foster raised this a little: The extraordinary change in the workforce.

Columbia, again, is not of the most advanced on this. But 50 percent of the medical school class is now women. When you said, by the by, that there are no white men, what was the field? I mean, I didn't know if you were talking about ob-gyn or peds.

DR. FOSTER: I was talking about internal medicine.

PROF. ROTHMAN: Internal medicine. Well, it's not quite that way at Columbia and New York. But the predominance of women — and that raises another kind of fascinating issue in professionalism that I'm just going to drop with you as closing.

A lot of the "good old days" boys talk about medicine as 24/7. You've got to be ready all the time, etcetera, etcetera. And I've been in rooms where young women professionals have said, "Don't you dare define medical professionalism as requiring me not to have children, not to pay attention to my children, not to be married, not to be able to," you know. And the conflict of interest, which is not only financial, but, you know, "My kid's in a play today," or, you know, "It's my anniversary," those sorts of issues, which I think again are very, very important, and I'm not sure that looking back will give us all the answers.

I guess what I was trying to do mostly today, and then I'll stop, is we're really into some interestingly novel new areas. And although the look back is useful and it can tell us some things, the interesting challenges are the changes in the profession, the changes in the society, and in the context of the practice of medicine and how does professionalism become relevant to those new developments, whether it's women, whether it's the kind of financial incentives that you describe, or the other issues that we've described today.

It's exciting, and I'm comfortable thinking about it more collectively. Look, a lot of people think about that doctor-patient relationship. Less of us are thinking about the larger context of the profession. And it's been exciting to do it and it's actually been fun, and I thank you for making it even more interesting and challenging.

I've enjoyed this question and answer period and discussion enormously, and my gratitude to you for having me here.

CHAIRMAN PELLEGRINO: And we thank you very, very much, Dr. Rothman. Your contribution was spirited, informative, stimulating, provocative, and not always right.

(Laughter.)

PROF. ROTHMAN: I accept all of that. Thank you.

CHAIRMAN PELLEGRINO: We will return at 2:00 o'clock. I think we can make that even with the overrun.

(Whereupon, the proceedings in the foregoing matter went off the record at 12:20 p.m. and went back on the record at 2:00 p.m.)

SESSION 3: THE "CRISIS" IN THE ETHICS AND PROFESSION OF MEDICINE: THE PERSPECTIVE OF MEDICAL EDUCATION

CHAIRMAN PELLEGRINO: This afternoon we will continue the discussion of professionalism, and we will begin the discussion with Dr. Jordan Cohen, who is Professor Emeritus of the Association of American Medical Colleges, and very much instrumental in the development of current ideas and contemporary directions in professionalism.

Jordan, it's all yours.

DR. COHEN: Thank you very much, Ed, and to the Council for the invitation. It's really an honor and a privilege to be able to share some thoughts with you. I was very much informed by the discussion this morning that David Rothman stimulated. I think your comments and your questions were awe inspiring, I must say. So I'm not sure I can answer the gauntlet that David threw down at me, but I will give it my best shot.

Anyway, how do I give my presentation? If I just do this, something good will happen (indicating microphone). Fabulous, good.

Well, I want to begin with a quote from a wise man that I once knew, who said, "Across history, culture, nation, ill persons are vulnerable, dependent, nervous, fearful, and perhaps most importantly, exploitable. They are dependent upon physicians' technical knowledge and skill. The physician invites trust" - and I would urge you to keep that word in mind" - and the patient is forced to trust. Fidelity to this trust is the moral compass that must always be the profession's guide." You won't be surprised who said that.

So Dr. Pellegrino not only has inspired much of the contemporary discussion about professionalism and the ethical and moral foundations of medicine, but I also, in the interests of full disclosure, have to tell you that he was my academic grandfather.

One of the medical schools he started at [State University of New York at] Stonybrook, I had the

privilege of being the dean once removed from Ed's tenure there. So I have had the privilege of knowing him and admiring him for a very long time.

Well, let me hearken back to your June Council meeting, because, again, I thank you for giving us the opportunity to review that session, and particularly the comments of William Sullivan, who presented the theoretical basis for the importance of professions, professional work and professionalism.

And I took away, at least his take-home message to me was, that society reaps essential benefits from professions as long as professionals adhere to the core principle of professionalism, that is, placing public interest ahead of self interest.

And then Arnold Relman, in a very impassioned recitation of his concerns, he detailed what many of us I think are concerned about, the contemporary threat to professionalism that is posed by commercialism and by the investor-owned enterprises that have proliferated over the last several years in our health care system.

His take-home message was we should purge the healthcare system of the alien profit-oriented value system of commercialism and restore the traditional service-oriented value system of professionalism.

Well, what David Leach and I have been asked to share with you today is the perspective of medical education. And I'm going to take the medical school, the undergraduate medical education perspective, and David will follow with the second phase of formal education, the graduate medical education.

But from the medical school's perspective, and again, I have to confess this is as much my own personal perspective as the medical school's perspective - I'm not sure I can speak for the medical school perspective - but from my perspective, I think the threat that Dr. Relman highlighted is clearly real.

At least in my professional lifetime, I don't think I've ever seen a period of time when there has been as much concern and assault on the basic fundamental commitment of professionals to their ethical foundations as is the case today.

And I often try to capture this in contrasting the models of commercialism, or the marketplace, with the motto of medicine. The motto of the marketplace is "Caveat emptor," buyer beware. When you enter into a commercial transaction, you have to assume that the person on the other side of that transaction is interested in his or her purposes and self-interest, not primarily interested in your interest and concerns.

The motto of medicine? "Primum non nocere," "First, do no harm." The first obligation of the professional, the medical professional, is to insure that that interaction is to the benefit of the patient, and certainly not to the harm of the patient.

So that, at least to me, captures the tension between the commercialism ethic and the professional, medical professional ethic. And it's captured in a lot of the verbs, or a lot of the words that we use to describe those interactions.

We have "patients" rather than "customers." We have "doctors" rather than "providers." We have "care" rather than "profit." So a lot of what is in the vernacular I think captures this important difference — and the degree.

As Dr. Relman expressed extensively and very well, there is a real threat to the fundamental medical ethic by the commercial enterprises that are so much in evidence in medicine today. So the threat is real.

Trust in the medical profession does appear to be waning. In fact, there are some studies that document, in terms of public polling, that the public is less confident about the profession. They still express a great deal of confidence about their individual physician, but they have over time seemed to be less convinced that the profession as a whole is organized and behaving in a way that is to their particular liking or expectation.

So I do think, again, anecdotally, and again, Professor Rothman gave you a series of recent articles and they are coming, as he said, daily, that sort of document in the public press the concern that's being expressed in that arena about the lack of professionalism among some of our colleagues.

And clearly, I think, at least I would argue, that sustaining trust is absolutely critical for insuring safe and effective care. And why do I say that? Because I don't think that there is anything that can protect the patients like trustworthy physicians.

We can't depend upon the marketplace to have a primary interest in protecting patients' interest. Nor do I think we can depend upon government to establish regulations that can prevent the potential dangers that entering the medical interaction poses.

So, no laws, no regulations, no patient bill of rights, no watchdog federal agency, no fine print in an insurance policy, and certainly not even the President's Council on Bioethics, I think, can substitute for having a trustworthy physician who is honor-bound to act in such a way as to be in the best interests of the patients and of the public.

Now, what is professionalism? Well, as has been discussed several times, it's been bandied about, there's lots of different definitions. The one that I tend to focus on, the one that I use in my own teaching, is an articulation by a consortium of organizations, the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and interestingly, the European Federation of Internal Medicine.

This was an effort to try to see whether or not in the contemporary world of medicine one could articulate or identify a set of principles and responsibilities for physicians that were transnational, at least transatlantic in nature, and not just specific to the American circumstance.

So this group was convened with the representation of our European colleagues to see if one could come up with a statement that captured in contemporary vernacular the fundamental principles and responsibilities of professionals.

And the Physician Charter that you may already have had presented to you in one form or another, but I want to briefly remind you what the Charter called for, because I do think it answers at least some of the issues that Dr. Kass mentioned earlier today about the difference between a healer and a professional.

The fundamental principles that this group identified were sort of the time-honored pre-Hippocrates principle, the primacy of patient welfare. I think that's the touchstone of every affirmation of professionalism that I've ever read.

A more recent, but I think, again, historically quite old view of professionalism is based on the principle of patient autonomy, that patients have individual rights and a sense of identity, that one cannot violate a competent patient's interests or desires.

So one always has to be operating with the notion that the patient is an autonomous human being who has his or her own set of values and interests in that transaction.

As far as I know, there has been no previous formal statement of medical professionalism that has as explicitly included social justice as part of the individual physician's professional responsibility as a principle of those responsibilities.

But the Charter group felt that given the modern world with all its complexities and all of the difficulties that are involved in the organization of medicine and the financing and delivery of healthcare, that social justice was an important element of the commitment of physicians to professionalism.

And it went on then to identify ten categories of professional commitments that were called for under the three principles.

The first, professional competence. Obviously, a fundamental requirement, and again, Dr. Kass, I think, this is the healer component of the doctor's responsibility, to be competent, to have the expertise that is advertised, and to deliver that competence and maintain that competence through a lifetime of a career. And that is a fundamental commitment, to maintain that competence.

And I'm sure Dr. Leach will speak more about that, because that's a very important part of the modern challenge to professionalism, is to maintain that competence through a lifetime.

Second is to be honest with patients. Again, a fundamental responsibility, commitment of physicians, always to be honest, to maintain patient confidentiality, to maintain appropriate relations with patients, not to abuse the power gradient that almost always exists between doctor and patient, to be sure that that gradient is not exploited at the disadvantage of patients with sexual

abuse, other kinds of inappropriate relations.

Scientific knowledge. A commitment to use scientific knowledge, evidence-based medicine, use the best science that's available for the decisions that are made. But also to continue to support the advance of the scientific basis of medicine, continuing to explore new knowledge and develop new ways and better ways of delivering healthcare to our patients.

Professional responsibility. Much of what Dr. Rothman spoke about this morning was the commitment of individual physicians, professionals, to maintain a professional set of organizational structures that can in fact interdigitate with society in such a way as to fulfill the professional commitments. So individual physicians in this view should be committed to involving themselves in professional responsibilities in order to fulfill their obligations under the social contract.

Now, the next three are really under the rubric of social justice and getting into the issue of civic professionalism, if you will. Improving the quality of care—something, again, that is terribly important, given what we now know about the errors that are rife in medical practice and some of the difficulties of maintaining a patient's safety in our systems, taking advantage of the knowledge that we now know from other walks of life about the way to improve, continuously improve the quality of care.

To improve access to care. Again, individual physicians have a limited ability in their own individual practices to improve access to care, although that's always been a traditional commitment. The AMA has called for physicians always to open up their practices to indigent patients. But clearly it's a commitment that needs to go beyond the individual physician.

And a just distribution of resources. Similarly, there's only so much individual physicians can do in their dyadic relationship with patients to insure the just distribution of resources. But a commitment to involve themselves in a civic professionalism to accomplish this.

And finally, and I would say most importantly, clearly from the standpoint of our discussion today, is to maintain trust by managing conflicts of interest. Again, the conflicts of interest that Dr. Relman spoke of and Dr. Rothman spoke of this morning I think are inevitable in our complex circumstance. And our obligation as medical professionals and to fulfill the commitment of professionalism is to manage those conflicts of interest. Eradicate them when possible, but recognizing that it's not ever possible to completely eradicate conflicts of interest.

We all have conflicts of interest in everything we do, not just in our professional work. And so it's not a question of eliminating conflicts of interest, but it's recognizing them, managing them, insuring that they do not overarch or trump our commitments as professionals when we're in that kind of relationship.

Well, that's sort of the framework in which medical educators now are trying to fulfill their obligation. And I just wanted to say a few words about that.

So, sustaining trust is what fundamentally professionalism is all about. It's maintaining this understanding between individual patients and their doctors and between the public at large and the profession as a whole that we can be trusted with this responsibility that we have to work in the public interest.

Professionalism in medicine is centered on the primacy of patient interest. And we had an interesting discussion this morning about what patient interest is. And I would concede that that is a very vague term, in terms of the kinds of interests that we're talking about.

But in the context of this discussion, I think we're talking about what is in the best interests of insuring and maintaining that a patient's health is the interest that that patient has when entering this relationship.

What a professional does is choose voluntarily, and I think that's an important part of this notion, that this is an honor-bound commitment, a voluntary commitment, to place the patient's interest ahead of one's self interest.

Clearly, we all have self interest. There is no denying that, or we should not shy away from that recognition. But it's a question of how you balance one's own interest against the obligation of a professional to voluntarily concede that interest in favor of the patient's interest.

Rampant commercialism in today's health care system does in fact, I think, offer unprecedented temptations to physicians to yield to self interest. And here I want to make the point that I think is

obvious to all of you, namely, that we've never, in the history that I know of in medicine, been free of temptation to violate this ethic of primacy of patient interest.

There's always opportunity. There always have been opportunities for physicians to express their self interest, in how often they see a patient, what tests to order, what diagnoses to make—all kinds of ways in which the relationship between a doctor and a patient can be exploited for self interest. And that's never been absent from medicine in time out of mind.

What is, I think, changed in the modern era is the magnitude—the extent of those opportunities and the magnitude of those opportunities for temptation. So Relman's answer to this dilemma, or this reality of the temptations that are so much in evidence, is to reduce those temptations. And I don't think one should discount the absolute importance of that effort.

Whatever we can do to restore a better balance between the temptations that are always there and what physicians have to confront in fulfilling their professional obligations is clear. But clearly, to reduce those temptations to the extent possible is a very important part of the effort to try to sustain professionalism under the modern circumstances.

And I would say as a quick and dirty summary of what medical education's answer to this dilemma is, is that we are responsible as educators to bolster the resolve of future physicians so that they can withstand the inevitable temptations that are there. So we don't see the job of education as addressing these larger societal issues, although I will come back to that at the end of my talk.

But rather, our focus is recognizing that those temptations are always going to be there in some form or another, no matter how successful we are in reducing them, but that we want to be sure that our trainees, our students and our trainees, are sufficiently fortified with their commitment to this fundamental ethic so that they can withstand these temptations and maintain their resolve to keep the patient's interest uppermost.

So, how do medical schools go about doing that? And again, I was very taken with the article in your agenda book by Coulehan, who talked a lot about the current ability and mechanisms that are at play in medical schools to try to bolster professionalism. And I think he's right, that we haven't yet done an adequate job.

We have a lot more that we can do and should be doing in order to make this more of a reality. And I think some of his suggestions are extremely well put. Another Stonybrook graduate, by the way, just to give proper acknowledgment to Dr. Pellegrino's legacy.

In any event, the first thing, and perhaps the most important thing that medical educators at the medical school level can do is to insure that the students who are accepted into medical school, as best we can, have the requisite character traits in order to provide the substrate to develop these professional commitments.

And this is, I think, a task that medical schools have understood for a long time. We recognize that, given the fact that - I don't know what the figure is currently - but something like 97 percent of medical students who are admitted to medical school receive the M.D. degree. Many of those who don't graduate choose to leave medical school, for reasons that they just made the wrong choice.

So it's very difficult to flunk out of medical school. It takes a lot of effort to flunk out of medical school. So the upshot of that is that the medical school admissions committee is really the entry point to the profession. They are the gatekeepers, if you will. That's where people get from laity into the priesthood, is through the door of the medical school admissions process.

So there's a tremendous amount of importance that's laid at the doorstep of the admissions office in order to develop whatever techniques they can to insure that those students who do gain entrance to medical school have the requisite character traits.

And as I'm sure you know, there are now over twice as many students applying to medical school as there are places in our current medical school classes. So this is a daunting task, to try to select among those very talented people, those that have not only the intellectual and academic backgrounds that are predictive of success, but they also have the evidence of these character traits.

Now, how do you measure that? What sort of tools are used? We all recognize that we have very imprecise ways of identifying students who are truly committed to these professional norms and the moral basis of the profession.

But I think by and large, admissions committees do a very good job. There are very few students who

turn out to be psychopathic or really fall far short of the expectations of the profession, not to say that there isn't a great deal more that we could and should be doing in order to sharpen that requirement, and sharpen that decision-making so that we can even more certain that these students that we admit do in fact have these requisite traits.

My own anecdotal observation - and I'd be interested in you all's view of this yourself - I think we are admitting an exceptionally talented, idealistic, committed group of students. And I would credit some of that to the fact that we now have as many women as we have men in the entering class. I think the women have done a lot to improve the atmosphere of the profession and have, I think, contributed to this sense of service, sense of obligation to others.

In any event, whether that is a reality or not, the fact is - or at least the impression I have, the strong impression I have, is that the students that are now coming into the profession are endowed with a very rich resource of personal characteristics that I think ensure that if we can keep that alive - and that's the big challenge-that we will have a future cadre of physicians that will in fact be resilient to the threats and the temptations that are out there.

Well, secondly, it's clear that at least one of the things medical schools need to do is to organize their formal curriculum so they can address not only the rationale for professionalism, but also be sure that our students understand what the barriers and the threats to professionalism are as they go through their professional lives.

Again, I agree with Dr. Foster that the formal curriculum is important, but clearly not the be all and end-all. It's nowhere near as important as the role modeling and the kind of experience that students have going through particularly their clinical education.

But nevertheless, I would like to underscore the fact that there is a need for some formalism, some didactic experiences, some knowledge base and cognitive understanding of what professionalism is about, its historical underpinnings, and, again, particularly the threats that our students and residents will eventually encounter during their professional life, to maintaining a commitment to those fundamental responsibilities.

And here's the issue of the informal curriculum, or the hidden curriculum, as it's been called. And I don't think there's any question about the fact that many of our learning environments, particularly in the clinical settings, are not emblematic of the kind of professionalism that we'd like to see communicated to our students.

There is also no question about the fact that students take away much more strongly the lessons from what they see rather than from what we say. And we need to recognize that our behavior, our interactions with each other as professionals, our interactions with our patients, the way the institutions operate in terms of their commitment to institutional ethics-all of those things contribute to an environment that presently is not nearly as conducive to bolstering this commitment to professionalism as it needs to be.

We need to recognize that we have crucibles of cynicism, as I've called them, that we have many learning environments in which our students are not exposed and witness the kind of level, the standard of care, standard of interaction, standard of relationships that we would like to see. We need to convert those into cradles of professionalism, recognizing that that is where professional identity is truly established in this educational context.

And finally, I think we need to be much more objective, much more precise about what we expect physicians, future physicians, to exhibit before they graduate. We need to give them a prospective understanding, not only of the knowledge and the technical skills that they need to demonstrate, but also the attitudinal and behavioral attributes that define professionalism.

And we need to have much better ways of evaluating the achievement of those professional objectives, just as we evaluate the achievement of a certain degree of knowledge and technical skill. We need to be willing and able and strong in our evaluations to sanction bad behavior, to not pass on from one class to the next students who we know have fallen short of this aspect of their professional responsibilities as well as their academic performance.

So sanctioning bad behavior is part of the responsibility of the institution. As important in fact, I think probably more importantly, to celebrate exemplars of professionalism, to have ways in which we can identify and hold up as exemplars the kinds of individuals and their individual performance that does give visibility to these values that we're trying to inculcate.

So there are many obstacles in medical schools, and I've identified some of these in passing. But just

let me repeat that one of the issues is cynicism among faculty role models.

We have faculty that are very stressed under the present time, by and large, with lots of responsibilities, lots of expectations that take their attention and their time and their commitment away from their fundamental obligation as faculty, namely, to teach and to pass on to the next generation these values that we're talking about.

And to the degree that our faculty have been frustrated in their attempts to maintain their professional identities, that's very easily communicated to the next generation.

So we need to understand that faculty are a key element here, and we need to help them maintain their commitment to professionalism, to honor that commitment, and to insure that what they are responsible for achieving in their multiple roles does not undercut and undervalue their function as role models for future physicians. It's a huge undertaking.

Again, a lot of what is going on, as I'll mention in a moment, is far beyond what the profession and what the school can really get its arms around, because so much of this is embedded in the system of healthcare that we are involved with that we have very little opportunity to directly influence.

But nevertheless, I think we have to recognize this as an issue and redouble our efforts to try to insure that faculty are not converted to cynics in the process.

Conflicts of interest in clinical research is another barrier. We've had, I think, a very interesting period in our country over the last several decades, where we've recognized the really very important public purpose that's served by academic institutions involving themselves with commercial entities and translating basic science discoveries into useful services and products for the public.

And this interaction, again, serves a very important public purpose. But it has a very important caveat, and that is the degree to which conflicts of interest, financial conflicts of interest in particular, can become embedded in those relationships to the degree that at least there's the perception, and I think clear evidence of some actual threats, to not only the objectivity of the research results, but more importantly, the safety of patients in clinical research when there is conflict of interest that overrides the fundamental commitment to maintaining patient safety in these clinical research enterprises.

So the fact that those conflicts of interest are evident in our institutions and in some instances not well managed I think again contributes to an atmosphere where professionalism is difficult to sustain, for students.

And as Dr. Rothman mentioned this morning, in detail, the intrusion of industry into the educational process in so many different ways, in terms of direct support for education, obviously, mostly continuing education, but increasingly in undergraduate and graduate medical education as well, there are attempts by industry, and some successful ones in fact, to involve themselves in a direct way, at least, again, with the potential of introducing bias into the educational process.

The gifting, the detailing, the faculty involvement in speaker's bureaus, in ghost-written articles and that whole gamut of issues that

Dr. Rothman detailed, I think again, [what] poses a clear obstacle to maintaining a focus on professionalism. When the institution and those involved, particularly in leadership in the institutions, are not adherent to these fundamental commitments, it does make it difficult for us to sustain the importance of professionalism among our students and residents.

And finally, I would mention the debt burden of graduates. I think somebody mentioned this morning that a graduate that they had talked to had a \$300,000 debt. That's a little bit extreme, but not greatly extreme.

The average indebtedness now of students who are graduating from medical school - and over 80 percent of students who graduate, by the way, have educational debt - and among that group, the average now is well in excess of \$100,000. Many students have \$150,000, \$200,000 of debt.

The degree to which that challenges their fundamental commitment to service is, I think, speculative. We don't have an awful lot of hard evidence about the relationship between debt and, for example, specialty choice. But I think it is reasonable, and a lot of anecdotal evidence [suggests] that this in fact does influence physicians' choice - or students' choice of career.

Certainly, once they are involved in having to repay that debt, it does put a higher value on

remunerative activities that they may engage in. And I think clearly the implicit message that we send to students by burdening them with this debt is not a salutary one from the standpoint of nurturing the future generation of physicians in a compassionate and understanding way. So I think this is an issue that is worth some discussion.

So, let me conclude by saying that medical schools clearly recognize the urgency of strengthening students' resolve to maintaining this primacy of the patient's interest by emphasizing professionalism, much more - there's just much more discussion of these topics in medical schools now than was the case even just a few years ago, stimulated again by a lot of the things that you've already heard about.

And I think the fact that there's now a recognition of the importance of this topic, it's being talked about, it's being debated, I think is obviously a very, very positive sign.

There have been clear, significant curricular innovations that are trying to address what many of us feel has been a deficiency in the educational activities in terms of trying to introduce not only a didactic, but also trying to address some of these issues in the hidden curriculum.

Stronger policies governing conflicts of interest - Dr. Rothman, again, mentioned several schools that have adopted very strong policies, managing conflicts of interest within their institutions, both at the level of clinical research as well as in the educational involvement.

We have, I think, a much more explicit reinforcement of the humanistic values of caring, compassion, altruism, empathy, that are character traits that we want to support.

I'm involved with the Arnold P. Gold Foundation for Humanism in Medicine, which is dedicated to trying to support the professional development of the humanistic qualities in the medical education arena.

The White Coat Ceremony that some of you may know about is a signature program of that foundation, again, at the beginning of medical school, trying to underscore the transition that is occurring from laity, if you will, into the profession, to ratify the importance of that transition, and the meaning that that has in terms of their future commitments.

We have, I think, to recognize that whatever success we may have in medical schools in terms of reinforcing these commitments that are largely there in the students that we've admitted, as I mentioned before, does depend upon the ability of graduate medical education and beyond to continue to develop those professional identities, and to bolster that commitment to professionalism throughout the subsequent phases.

I think we have the easiest job in undergraduate medical education. I think the residency, as Dr. Leach will document, I'm sure, is a much more difficult issue. That's where much of the cynicism, much of the unprofessional attributes that we worry about, I think, are in fact in evidence. So we need to recognize that we can only have a certain amount of success at the undergraduate level.

But even more important, I think success in maintaining and bolstering this commitment to professionalism depends absolutely and exclusively on improving the environment of medical practice, because that's the fundamental problem, again, that Dr. Relman emphasized and I think we have to come back to - that much of what hinders professionalism is clearly beyond the control of physicians or of the medical profession as a collective.

Again, I mentioned the Physician Charter. The Physician Charter has been endorsed by over a hundred medical organizations throughout the world. But a very strong feedback, a criticism of the Charter, is that it calls on physicians to do things that are beyond the physician's control.

Many of the things, as I'll mention in a moment, that the Charter expects physicians to fulfill as responsibilities are very difficult if not impossible to do given the circumstances of medical practice, certainly in this country. It's not true only here, but in the United States the system of medical care is antithetical in many respects, as I'll mention in a minute, to what needs to be done.

So if you accept the assertion that I mentioned at the beginning, and again, that Professor Sullivan emphasized in his remarks in June, if you believe that the public has a real stake in maintaining medical professionalism because of its fundamental safeguard to patients and the public, far beyond what can be accomplished by the market or by government regulation or any other mechanism, if professionalism and the voluntary commitment of physicians to this ethical code is in fact of public value, then it seems to me that we must have a joint effort between the profession and the broader public to address these system-wide barriers to professionalism that the profession itself cannot

alone manage.

And just to underscore what those might be, how are we going to manage conflicts of interest with a payment system misaligned, as it currently is-again, Dr. Rothman mentioned this this morning - that the current way in which we compensate or pay physicians for their services is in many respects antithetical to maintaining the primacy of patients' interests.

We need to address the inequities in the payment system and the mechanisms in that payment system and align them better with what we really want physicians to do in the final analysis.

Maintaining professional competence provides adequate support for the education and training of physicians. And burdening physicians with this much debt when they leave medical school is something that I think needs to be addressed.

And other supports of the medical education enterprise to ensure, for example, that faculty has sufficient time to devote to the professional development of trainees and students is critically important, and given the current circumstances, very difficult to accomplish. So we need a recognition in the broader public that that is an issue.

Maintaining scientific knowledge, obviously, giving adequate support for medical and health services research has always been acknowledged to be a public responsibility. But I think we have to continue to advocate on behalf of medical research so that our public policymakers and lawmakers understand the importance of that issue.

Maintaining honesty with patients is very difficult under the present circumstances of our liability system, where physicians are always threatened with lawsuits when they make what is perceived to be an error, or when an error occurs and when a misadventure occurs.

Maintaining a liability system that fosters frank discussion of those errors is the only way we are ever going to get to the point where we can identify the errors and improve the systems. Most of the errors, as you know, are related to system level problems, not individual malfeasance.

And unless we can frankly discuss those errors in an atmosphere that is free of the threat of personal professional liability, it's going to be very hard to get a handle on that issue.

So we've got to construct a liability system that fairly compensates individuals when they are injured by the system, which will inevitably be the case, but which doesn't at the same time squelch the ability to make improvements in the system.

We've got to improve access to care. Obviously, individual physicians in the profession can only do so much in providing adequate medical care to individuals who lack financial wherewithal, either because of their own personal resources or because they lack insurance for a basic set of preventative and medical care services. That's a clear example of where we need to have a partner with the broader public to achieve.

And finally, improving the quality of care. We've got to establish standards of inoperability for the electronic health record. We've got to have a regime of privacy laws that ensures that we can have access to the relevant patient level data so that we can in fact make improvements in the system.

All of these things, again, are fundamental commitments of the professional, the individual physician, that can only be achieved, I think, in partnership with the broader public.

So, with that I will end my remarks, and hope I haven't taken too much time. Thank you, Ed.

CHAIRMAN PELLEGRINO: Thank you very much, for a very complete and very, very incisive presentation on the whole range of issues involved in professional education.

With the indulgence of the Council, I've asked, and I will ask, Dr. David Leach to continue the discussion, and then the Council itself can put questions to both of the speakers simultaneously.

Dr. Leach is the Executive Director of the Accreditation Council on Graduate Medical Education, that area of medical education where really the habits and attitudes of physicians are most frequently and most strongly formed. Dr. Leach.

PRESENTATION BY DAVID LEACH, M.D.

DR. LEACH: Let me begin by thanking the Council and its distinguished members for the opportunity to share my thoughts and observations about medical professionalism, especially as it

applies to the formation of resident physicians.

Medicine, unlike most professions, requires a period of formal supervised training after graduation. These educational programs, called residencies, are accredited by my organization, the Accreditation Council for Graduate Medical Education, the ACGME. There are about 8,600 residency programs in the country, programs that in aggregate house about 106,000 residents in 122 different specialties and subspecialties.

Residency is an intense experience. There is probably no steeper learning curve in physician formation. The differences in knowledge and skill between a first-year and chief resident is profound. The resident's journey is one in which they learn both the practical skills of medicine, the clinical wisdom, but also they learn about themselves.

They are seeking to become authentic physicians. It's a journey that is surrounded by external drama, but which actually proceeds from the inside out. It is a journey that calls on their intellect, but also on their will and their imagination.

Residents learn to discern and to tell the truth and to make good clinical judgments in very complex clinical situations. Because of the intensity and importance of this most formative phase in physician development, and because the habits of a lifetime are developed during this period, we pay attention not only to the resident's progress, but also to the context in which residency occurs.

The learning environment is crucial and is monitored by ACGME's Institutional Review Committee. Residents in the residency programs offer a particular view of the issue you are studying - professionalism and whether there is a crisis in the medical profession.

One of my mentors, Parker Palmer, a sociologist in Madison, Wisconsin, has said, "Hope is not the same as optimism. An optimist ignores the facts in order to come to a comforting conclusion. But a hopeful person faces the facts without blinking, and then looks behind them for potentials that have yet to emerge, knowing that the human experiment would never have advanced if it were not for the possibilities, however slim, that lie behind the facts."

Using Palmer's definition, I can say that I am cautiously hopeful, but definitely concerned. In May of 2002, he facilitated a retreat for residency program directors who had received the ACGME's Parker Palmer Courage to Teach Award.

During the retreat, a case was presented, a case in which a liver transplant donor had died while in intensive care. He died despite the fact that the surgery had gone smoothly, and despite the fact that his wife, who was with him throughout the entire postsurgical period insisted repeatedly and to no avail that her husband was going downhill fast.

Three months later, the state health commissioner issued an incident report saying the hospital allowed the patient to undergo a major high-risk procedure and then left his postoperative care in the hands of an overburdened mostly junior staff without appropriate supervision.

On the day the donor died, a first-year surgical resident, having been a resident for three months, and having been in the transplant unit only 12 days, had been left alone to care for 34 patients. She could not and did not monitor every patient with the care and precision required.

I present this case as an example, perhaps an extreme example, of abandonment - not only of the patient but of a very junior resident. I also present it because of the response it evoked from a set of doctors analyzing it.

The doctors at the Courage to Teach retreat discussed the case in small groups, and almost universally came to the conclusion that system issues were to blame. The analysis was impersonal and abstract. The culpable parties were the hospital leadership, the clinical department chair, the system of supervision, inexperience in staffing.

During the debriefing, Parker Palmer asked the question that brought the group into deep silence, "Who is the moral agent of this story?" We were not used to thinking in terms of moral agency. The group agonized over the question, and the fact that by habit we had avoided asking the question.

Parker then inquired, "What if residents were expected to be the moral agents of the institutions in which they work and learn?" He suggested that young learners not yet acculturated by prevailing institutional mores offered a more pure look at the moral issues in health care than those of us who by experience and habit had developed a ready list of explanations to cope with such failings.

I realize that one topic of interest to this Council is the effect of various external forces on professionalism. For example, investor-owned interests in health care money and its influence, and even its influence on educational programs.

I share Dr. Relman's concerns. He has spoken and written eloquently, and I cannot add to his comments. Commercial support has some, but so far limited, direct influence on residency education.

We do have a position paper and guidelines on the topic, but I think it is fair to say that compared to commercialism's influence on the larger healthcare system, its role and influence in graduate education is quite limited.

Instead, I speak today more to the internal influences on the developing professional. I think of medical professionalism as more potato than lettuce. Lettuce rots from the outside in; a potato from the inside out. I put commercial support of education into the lettuce category. It should not happen. Fixing it might involve removing some of the outer leaves of the lettuce that appear brown and slimy.

For me and for many who take residency education seriously, the question of professionalism is deeper. How do we preserve and nurture authentic human moral reflexes in our young learners? How do we foster authentic professionalism and moral development in young people, when the context in which young people are being formed is itself challenged morally?

ACGME has identified professionalism as one of six general competencies used in the accreditation of residency programs. ACGME requirements about professionalism include this language: "Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

"Residents are expected to demonstrate respect, compassion and integrity, a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and ongoing professional development.

"Residents are expected to demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.

"To demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities."

As this definition makes clear, medical professionalism depends heavily on the quality of the physician's inner life. Transcendence of self-interest is not a technique; it is a way of being. The resident, in addition to learning the science and art of medicine must also learn a new way of being in the world in order to become a fully developed professional.

Their journey is an inner journey. We have a heavy obligation to help them. Though the journey is deeply personal and inner, it is heavily influenced by context, both institutional and societal context influence the development of professionalism.

Is it possible to model and teach professionalism in institutions that do not demonstrate professional values? Is it possible to teach and model professionalism in a society that does not demonstrate social justice, a society that accepts limited access to health care for the uninsured, and that tolerates demonstrably worse healthcare outcomes for the poor?

No, the current context in which healthcare and resident formation occur does not make the task of fostering medical professionalism easy. Relentless pressures of time and economics, fragmentation of care and the relationships supporting care, increasing external regulation, exciting but disruptive new knowledge and technologies, and above all, the broken systems of healthcare dominate conversations and characterize the external environmental context.

The internal context of the system of care is also daunting. We lie regularly. Justifiable lack of trust pervades the system. Beth McGlynn estimates that only 54 percent of the time do patients receive care that is known to be best - a number that falls to 2 to 3 percent of the time when evidence-based guidelines are bundled.

Hospital websites proudly announce that the hospitals they promote provide the best care with the best doctors, the best technology, et cetera. Some are so detached from acknowledging human suffering that they make it seem as though a hospital might be a fun place to visit.

As a profession, we have tolerated that messaging, forgetting Hannah Arendt's adage that every time we make a promise, we should plan for the forgiveness we will need when the promise is broken.

The hospital bill offers another example of a breach in professionalism. It is frequently not interpretable, even by the hospital's own administrative staff, let alone patients and their families.

Paul O'Neill has said that he knows of no other industry that regularly accepts a 38 percent reimbursement on amounts billed, a percentage that he states is the national average.

We all know how the number is derived. Hospitals actively negotiate with several insurers in ways designed to cover costs. Inflated bills and discounted deals result. This system, while cumbersome, works from the hospital's perspective as long as aggregate reimbursements cover expenses and some margin.

The system works fine, that is, until a patient shows up with no insurance. With no one to negotiate for a discounted rate, then the undiscounted fees are billed to those least able to pay. The hospital bill is about as far away from respect, compassion, and integrity, a responsiveness to the needs of patients, as one can get.

It's hard to foster professionalism when incongruities between espoused and evident behaviors are so apparent. I call this the "Abraham Verghesse problem." At a spectacular forum sponsored by the American Board of Internal Medicine in the summer of 2005, the audience was, with some justifiable pride, celebrating the accomplishments of the Physician Charter on Medical Professionalism.

This very well-written document endorsed by many clarifies principles and commitments in a very important way. And yet, in the midst of the celebratory speeches, Abraham Verghesse stood up and said that his medical students shrugged that the principles espoused in the Charter were self-evident, it was why they went into medicine. Why were so many making such a fuss about it?

Dr. Verghesse then said, "Perhaps we pay so much attention to the words because there is no other evidence that the phenomenon exists." Everyone became silent. In spite of these examples, I remain cautiously hopeful, using Palmer's definition. Why?

There is a deep hunger for a return to classic professional values. Many good people are seeking clarity about how to best do that in the modern world. And because, as Parker says, "in looking for the potentials that have yet to emerge, and at the possibilities hidden behind the facts," we can find allies that help us move this particular human enterprise forward.

Dee Hock has said, "Substance is enduring; form is ephemeral. Preserve substance; modify form; know the difference." The task before us is to be faithful stewards of the moral foundations of medical professionalism, while adapting to the new and emerging forms of medical practice.

If in fact medical professionalism is like a potato and not just lettuce, our response to the new forms of medical practice will either reveal deeper lesions of professional values or not. How can we best proceed?

I think it's best to work with rather than against human nature. Residents, their teachers and all humans come equipped with three faculties that are naturally aligned with the goals of professionalism: the intellect, the will, and the imagination.

The object of the intellect is truth; that of the will, goodness; and that of the imagination, beauty. The job of a good doctor boils down to discerning and telling the truth, putting what is good for the patient before what is good for the doctor, and making clinical judgments that harmonize-harmonize in ways that are creative and sometimes beautiful - the particular needs of a patient with the generalizable scientific evidence at hand.

This construct invites a new frame, or rather a very old frame, for organizing experiences. How good a job did I do in discerning and telling the truth, in putting the patient's interest first, in accommodating the particular realities of the patient's situation in my clinical judgments?

While we have a long way to go, some hospital websites are beginning to tell the truth about their clinical outcomes. If you go to the Dartmouth Hitchcock website, you will find a list of several clinical procedures and diseases and Dartmouth's performance for each displayed in three columns: Dartmouth's performance, national average, and national best performance.

While still unavailable for most hospitals, Dartmouth is not alone in its transparency. Others are beginning to follow. If you look at the Cystic Fibrosis Foundation website, you can get comparative outcome data for each of the major cystic fibrosis treatment centers in the country. While not yet true for other diseases, that inevitably will be. As a profession, we are beginning to tell the truth.

We are also beginning to tell the truth about medical error. Many hospitals now have formal programs in which patients are told exactly what happened, are given an apology, and some evidence that the hospital staff are working to reduce the probability of that error occurring again.

To do this work we must acknowledge that we the teachers of medicine must attend to our own inner landscape. Teachers who take resident formation seriously find that both resident and teacher are changed. The journey to authenticity is not being taken by the resident and faculty alone. The profession of medicine is on the same journey.

For that matter, our American society is on a journey to authenticity as well. To the extent that our profession discerns and tells the truth about healthcare, to the extent that it puts what is good for the patient and the public before what is good for the doctor, and to the extent that it is creative and generative, it is an authentic profession.

Authenticity in this sense is a verb, not a noun. It is not a state of rest. It requires constant vigilance. Residencies and the institutions that house them should be built on the bedrock of the intellect, the will and the imagination, and offer experiences that strengthen and test these capacities.

We must debunk the myth that our institutions are external to ourselves. We tend to accuse others of our own sins. We tend to blame the nebulous "they" for violations of standards that we alone and together must defend.

This from Parker Palmer: "Professionals who by any standard are among the most powerful people on the planet have the bad habit of telling victim stories to excuse behavior. 'The devil made me do it.' The extent to which institutions control our lives depends on our own inner calculus about what we value most.

"These institutions are neither external to us nor constraining, neither separate from us nor alien. In fact, institutions are us. The shadows that institutions cast over our ethical lives are the exterior manifestations of our own inner shadows, individual and collective.

"If institutions are rigid, it is because we fear change. If institutions are heedless of human need, it is because something in us is heedless as well."

In our journey to authenticity as a profession, we must call institutions to account as we call ourselves to account. We may pay a price; we may be marginalized, demoted or even dismissed. But the price we pay for continuing to pretend that we are helpless victims, the price we pay for living professional lives in conflict with our deepest values, is greater.

We must resist unprofessional institutional behavior not because we hate our institutions, but because we love them too much to allow them to fall to their most degraded state. Perhaps we should take seriously Palmer's suggestion that we create a system in which residents and other early learners could function as moral agents.

Like the canary in the coal mine, they could detect and warn others when institutional conditions and relationships are toxic to professional values. They could keep us honest about how we are dealing with the sick.

This approach would require that we both listen to and validate residents' feelings, and that we train them to use the human heart as a source of information. This, of course, is problematic. Embedded in the higher education process is a systematic discounting of the subjective. It is thought to be a source of bias and unreliability.

And yet, good physicians do more than simply pay attention to objective details. Compassion, empathy, and deep respect are all dependent on truths revealed by the human heart. Perhaps the heart, like the mind, can be taught to discern truths. Perhaps when the heart is uneasy, we should listen more carefully and mind the information it is giving us. Perhaps a disciplined approach could enable moral agency to develop.

Lacking a disciplined approach, we too frequently socialize residents to cope with, rather than to master, the systems in which they work and learn. They live in the cracks of a broken system; they

are the glue that hold it together. They get things done.

Yet, as many have said, they are renters and not owners. They can identify system issues but don't feel empowered to fix them. Coping with systems in which patient safety depends on individual vigilance rather than design is wearing and dangerous, and we will fail every hundred or thousand times, well below what we know is achievable in other sectors of our society today.

It also inhibits the formation of true professionalism. The solution requires attention to group as well as individual formation. We have assumed that professionalism is an attribute of individuals alone. It is not. It also marks communities.

The assumption that the doctor-patient relationship is a one-to-one relationship is flawed. In fact, it is more like a twenty-to-one relationship, with several different types of doctors, nurses, and other healthcare professionals interacting with the patient and each other in ways that are variable and frequently disorganized. Needed is clarity about the roles, authorities, and functions of the various members of the healthcare team.

Cultivating communities to discern and tell the truth to each other, to enable and facilitate altruism, to make good promises and to seek forgiveness, and to harmoniously integrate true hospitality into care plans depends on paying attention to small group as well as individual formation. It will help us respond to society's call for respect.

Lastly, we must not stand passively by when our country violates fundamental principles of social justice. Every resident physician encounters the poor. Many academic health centers include care of the poor as part of their mission, and are frequently the backbone of such care for their communities.

Yet widespread disparity exists across the larger society even within academic centers. The profession has been ineffective at best and silent at worst about healthcare disparity. We would be well served to have a bias toward rather than against the poor. The larger society judges us over time by our response to their needs.

We live in a society in which truth is viewed as nothing more than a social construct. Spin doctors rather than real doctors prevail. They can construct a view of social justice that will serve their master.

Medicine in its very nature functions under a different set of assumptions. Rather than a postmodern socially constructed view of truth, doctors deal with things like gallstones and brain tumors. Medicine accepts that there is a truth and that it can be known, although sometimes with great difficulty. A gallstone is not a social construct.

A doctor may or may not be able to detect it, but ultimately, truth trumps opinion. If we by habit discern and tell the truth, we can offer the larger society an approach to truth that conforms with reality, rather than mere social constructs that attempt to create reality.

Good doctors are humble. Even the arrogant ones encounter failure. Postmodernists lack that corrective and can become quite proud, marked by hubris and convinced that they are right. Flannery O'Connor has said, "In the absence of the absolute, the relative becomes absolute." This is the source of all fundamentalism, religious, political or other.

We cannot accept socially constructed views of social justice. This is not an issue of conservative or liberal. It is deeper than that. We are called upon to provide health care for all of our citizens. It is their due. In a society with resources and know-how, failure to care for the sick is a breach of professionalism.

Further, we must respond to the needs of all of our citizens in ways that offer an exemplar for our young learners. They, too, will judge our words and actions and grade us on professionalism. When idealistic young people are told to adjust their values downward in order to accommodate our accommodation, we have a problem.

If we get this right, the crisis in professionalism will fade, and we will have achieved the next step on our own journey to authenticity. We can deal with external threats once our internal values are sound and our courage is found. Thank you very much.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Leach. Dr. Carson has consented to open up the discussion.

DR. CARSON: I want to thank both of you gentlemen for your discussion and for the very long-term contributions you've made to the training of physicians in this country. Now, this is a very, very in depth type of discussion that needs to be had about this. I don't know that it can be actually done in the amount of time that we have, because it really is a problem.

I don't know if it's crisis or if it's just a problem, but it certainly does need to be addressed. Our whole concept of how do we make patients' welfare the most important agenda item - I think that's perhaps the most important part of professionalism.

And I'm going to ask a series of questions in response to what's been said and what's been written here, just to get us started. The whole concept of can we actually select out people who are prone to act in a professional way, or can we take people who perhaps aren't prone to acting that way and train them to act in that way?

That's a very profound question. Which one of those is true? Are they both true? Perhaps not. How good are we at determining who is going to be a good physician?

I can remember in my own case, when I was a first-year medical student, after the first six weeks having a comprehensive exam and not doing very well on it, and being sent to see my counselor, who looked at my record and said, "You seem like a very intelligent young man. I'll bet there are a lot of things you could do outside of medicine."

And he encouraged me to drop out of medical school. He said I wasn't cut out to be a doctor, and I'd only invested six weeks, so why waste everybody's time, just drop out. Well, obviously I didn't listen to him. I must say I was looking for him when I went back to my medical school as the commencement speaker, because I was going to tell him he wasn't cut out to be a counselor.

But, you know, in so many cases we actually do think that we know, and it may be more complex than we think. Now, no one can deny that there are a lot of problems. One of the problems is, is medicine able to attract the best and the brightest anymore?

There was a time when people were very much attracted to medicine because it was going to provide them with significant independence, they didn't have to have 300 hoops to jump through in order to do what they thought was the right thing to do, they thought they were remunerated fairly, they felt that it was a very prestigious job.

I think that may have something to do with the change that we see in the demographics of people who are going into medicine. Maybe that's good; maybe that's bad. It's probably something that needs to be discussed.

Are the liabilities of practice too great? Are the tangible rewards too small for the time and the effort commitment? If the answer to that is yes, are there things that we should be doing to address that, and are there consequences if we fail to do that?

Are there models that we can look at around the world, of places where the tangible rewards for medicine were removed, and what happened in those situations? Need we learn from those things?

Now, in terms of some of the many ethical issues, new knowledge and technologies are certainly going to bring some new moral issues. For instance, because we can keep people alive for 150 to 200 years, should we do it? These are issues that the new professional is going to have to face.

Should we choose a baby's sex because we have the ability to do that? As medical professionals, are we servants of the client? Because they decide they want to have a boy and we have the ability to insure that they have a boy, should we do that, knowing what the long-term consequences of those kinds of things are?

I think those are major ethical issues that we need to address with students. Should we create organs, spare parts, and if so, to what extent? Is it okay to create an eyeball but not a face? A kidney but not an entire abdomen? I mean, where do we draw the line with these kinds of technologies that will become available to us?

When we have the ability to bring a fetus to term outside of the uterus, will we have to redefine viability? Another big one, when all information is electronically and digitally available to us instantly, what will be the role of memorizing things in medical education? That's coming.

Now, there was a time also, just moving to another area here, when most physicians gladly provided care for the poor. But that was a time when they were fairly reimbursed by insurance companies,

and there was the ability to spread costs over a number of different people. That's no longer the case.

I'm reminded of a case just two weeks ago, a little girl from Maine who had a very, very complex spinal condition. She has achondroplasia, has been operated on a couple of times, and the problem is not going away. It's going to require some very, very intricate surgery. But it's going to require both my services and pediatric orthopedic services.

The patient has Medicaid of Maine. Their reimbursement is 5 percent of the charge. I said I would accept the 5 percent. The orthopedic surgeon involved said, "Forget it," not happy. And I don't particularly blame him.

But, you know, there was a time when if there was somebody who was indigent, you could just say, "Write it off. No problem." And you wouldn't have a problem from the hospital because there was enough of a pot of money, and nobody really got bent out of shape. It doesn't happen anymore.

Medicare was supposed to help solve that kind of problem, and maybe initially it did. And someone made mention of the fact that physician reimbursements went up significantly when Medicare was first established. That perhaps was the case, but at that point, reimbursements from Medicare were significantly higher than they are now. They've continued to go down, and then other reimbursements have been indexed to that.

So those are issues that can't just be discarded and not looked at in terms of the impact that they have. And is there so much emphasis on professionalism that we in the medical profession have dropped the ball on finances, and allowed that to be taken over by other people, instead of, you know, trying to take charge of that ourselves and perhaps making sure that things are more equitably distributed, as opposed to putting it in the hands of people who are business-oriented and are interested in making money for themselves and really could care less about what happens to patients.

And I would be the first to admit that the medical profession has dropped the ball on that. But it may be not too late to pick it up again.

Now, in terms of outside influences, research dollars are getting harder and harder to find. And of course, that has led to the alliance with industry-drug companies, device companies, in a very significant way. And there's no question that that can have a deleterious effect.

But, can we just say, "Stop it," and not have anything to replace it with? And is there maybe a larger responsibility towards society to say, you know, what those dollars from the drug companies are providing is something that is important.

And is there another way that we can provide those dollars for that research for the various things that need to be done? I don't think we can just say, "You guys are bad, all of you are bad, a curse on your houses," and let it go away. It doesn't work that way.

Now, I'm going to come back to the idea of our social responsibilities momentarily. Now, there is significant blame to go around. Most physicians find repugnant the incredibly large fees exacted by liability attorneys, particularly malpractice attorneys.

But isn't it really just as bad from a moral and ethical point of view for physicians to collect fees for treatment of hopelessly terminal patients, when it's known that those are hopelessly terminal patients? Doing procedures on them and collecting fees I believe is reprehensible, something that we frequently just don't talk about. And I believe those things need to be talked about, particularly in terms of looking at the way that we can more equitably distribute resources.

Someone mentioned this morning - no, it was actually mentioned in one of the articles that we need to coax physicians into seeing uninsured patients. Now, you know, that sounds nice. But we also have to look at the practical reality that the people who are most likely to bring lawsuits are those very indigent patients, looking at the statistics. If we're going to be coaxing people to see these patients, we clearly are going to have to reform medical malpractice.

Now, also, one of the articles talked about the importance of getting the media to take a role in this. But the media, you know, I have mixed feelings about the media and their responsibility.

I wrote a column for the Washington Post a few years ago about medical liability and the fact that it always gets through the Congress, but whenever it comes to the Senate - it gets through the House, and whenever it comes to the Senate, even though there's enough votes to pass it, it never gets voted

on because of a couple of filibustering senators who are in the hip pocket of certain special interest groups. And that the media has responsibility to shine the light on those filibustering senators. But they haven't done it. So, you know, I just wonder how reliable they would be in helping us with these various problems.

Now, getting to the pharmaceutical companies, they're not all horrible people. Some of them actually produce pretty good products, actually. But I wonder if maybe they should be publicly graded, the same way hospitals are, in terms of their relationships with the medical profession.

They are exquisitely sensitive to public scrutiny and to their reputations. And there may be ways that we can take advantage of that. The ones who don't bribe physicians get an "A"; the ones who bribe everybody get an "E," you know. If this was done on a regular basis, I think it could probably have some impact.

Now, moving to the residency issue, a few years ago, I think most of us are aware of the fact that there was a major change in the hours. And residents are now only allowed to work 80 hours a week. In certain specialties they get an exemption and work 88 hours a week. That, along with some other types of changes, have resulted in large part to a different type of mentality when it comes to identifying patients as "my patient."

And there's more of a "This is my shift" than there is "This is my patient" type of mentality. Now, I don't think that's going to go away. But what we need to figure out is a way to work within that framework to try to reestablish that relationship that I think was so important.

When I was - if I had a patient who was having a problem, there was no way I was going to leave. I mean, I wanted to deal with that situation. And I think most of us in the older generation probably felt that way. And we're dinosaurs in that regard. But is there something that we can do to help foster that type of relationship once again?

And another thing, physicians in training do tend to model what they see. If you look at most surgical interns, they're very nice people - considerate, reasonable. And by the time they're chief resident, most of them are not like that anymore.

Now, what happened during those years? Watching people yelling, throwing instruments around and acting like they're God reincarnated. You know, this is craziness. And yet, I see it tolerated, and it really should not be tolerated.

We in medicine fall down when we do not call people on that kind of infantile behavior, which is then re-modeled by those coming along. It becomes sort of a rite of passage.

Also, should we continue to teach emotional detachment? We tell doctors, we tell nurses in training, "Don't become emotionally attached to your patients, because you're going to burn out and because it's going to be harmful to you in the long run." Now, I've never discovered how to do that, myself.

And does it hurt when something happens to one of your patients? Absolutely. It's extraordinarily painful. But you can get over it if you know you've done your best. And, you know, I think we need to reexamine that whole concept.

And finally, making healthcare affordable and available to everybody is perhaps the biggest ethical issue facing our nation today. And I think for a Council like ours, in terms of having some real, tangible recommendations to make for the President and for the Congress, we really need to be looking at what's wrong with a system that has plenty of money in it, but has so much disparity in terms of the way that it's distributed.

And, once again, thank you all for what you've presented.

CHAIRMAN PELLEGRINO: Thank you very much, Dr. Carson. I will now open the discussion - Diana, you had your hand up first.

PROF. SCHAUB: I just want to say I'm sort of surprised by the emphasis on transcending self interest. I admit that there can be a conflict between the patient's interest and the doctor's interest, but only when the doctor isn't really a doctor. And I have a wonderful little story that Booker T. Washington tells that I think illustrates this point. It's just a couple of paragraphs.

"In a certain community there was a colored doctor of the old school who knew little about modern ideas of medicine, but who in some way had gained the confidence of the people and had made considerable money by his own peculiar methods of treatment.

In this community there was an old lady who happened to be pretty well provided with the world's goods, and who thought she had a cancer. For 20 years she had enjoyed the luxury of having this old doctor treat her for that cancer.

As the old doctor became, thanks to the cancer and to other practice, pretty well-to-do, he decided to send one of his boys to a medical college. After graduating from the medical school, the young man returned home and his father took a vacation.

During this time, the old lady who was afflicted with the cancer called in the young man, who treated her. After a few weeks, the cancer, or what was supposed to be the cancer, disappeared, and the old lady declared herself well.

When the father of the boy returned and found the patient on her feet and perfectly well, he was outraged. He called the young man before him and said, 'My son, I find that you have cured that cancer case of mine. Now, son, let me tell you something. I educated you on that cancer, I put you through high school, through college, and finally through the medical school on that cancer. And now you, with your new ideas of practicing medicine, have come here and cured that cancer. Let me tell you, son, you have started all wrong. How do you expect to make a living practicing medicine in that way?' "

Now, if the father is right and there really is this sharp conflict between the patient's interest and self-interest, then it seems to me our only hope would be to cultivate altruism.

But the father isn't right, and the point of the story is that the father isn't right. The son is right. The son is truly a doctor, a healer. And for the son it seems to me there is no conflict between the good of the patient and his own self interest, because his self-interest is the self-interest of the doctor.

The quack, which is what his father is, lives often uneasily by duping a few; the good doctor makes a reputation for himself, and by his healing he lives securely and prosperously by serving the many.

So I guess I'm just a little uncertain about all the emphasis on withstanding temptation. It seems to me it's not really necessary if you understand yourself to be a healer. In that case, your self-interest would not be at odds with your patient's interests; they would coincide. You're guided by love.

The man who loves his wife doesn't have such a problem with the temptations of adultery. So it seems to me that what we need to think about is, you know, how do the institutions have to be structured to make sure that they don't undermine that love?

So calling on doctors to be professionals doesn't seem to me to be the answer. I mean, no kid grows up wanting to be a professional. I can't think of anything more deadly than being a professional. Kids grow up wanting to be a doctor, wanting to be a teacher, wanting to be a fireman.

So we need to figure out how to let doctors be doctors. And it may be, you know, that there are all kinds of things in the institutions that are interfering with that. But it seems to me when I listen to the doctors here speak, when I listened to Ben Carson, when I listened to Dan Foster or Paul McHugh, they really do embody this love.

CHAIRMAN PELLEGRINO: Do you want to answer?

DR. COHEN: A very interesting comment. With all due respect, I think it's a semantic issue that you're raising. In your vernacular, I would phrase it this way: what we want to do is convert doctors' sort of original self interest into the self interest of a doctor. So I don't care whether you call it self-interest or patient interest.

And I agree with you, I think doctors should have that motivation internally, strongly felt, voluntarily devoted to the doctor's sort of profession. And that's what we're trying to do.

So I think it's a confusion of words here. I don't think we're trying to avoid self interest. We're trying to convert the doctor's self interest into being in harmony with what the patient's interest is.

PROF. SCHAUB: Yes, I guess - I mean, it is a matter of words, but I think the words really matter, and that you can actually undercut what you're aiming at. I mean all the talk, for instance, about assessment. I'm in teaching, and we are also talking a lot about assessment and all of these regimes of assessment.

It seems to me that in many ways that really undermines the enterprise. I mean, I was struck by - at one point, at page 614, you talked about the bad apples, right? That there may be some way to sort

of figure out from a pretty early point which doctors, which future doctors, are going to be problematic.

It seems to me it might make sense to put some real emphasis there. You know, are there things that you could do to really figure out who doesn't belong in this enterprise? But the other kind of assessment, you know, constantly filling out forms and looking over people's shoulders and all of that might actually undermine the love that real doctors feel for their enterprise.

CHAIRMAN PELLEGRINO: Dr. Meilaender and Dr. Bloom, and Peter.

PROF. MEILAENDER: I'm next? I want to express - this is really in a certain way a continuation of a comment I made in the previous session. But I want to express just a certain frustration as I try to think about what this Council could think about or could do. I'll try to do this as compassionately and empathetically and so forth as I can.

But I'm just puzzled by a lot of things. Doctors are supposed to place the public interest above self-interest. Now, I mean, I'm not going to go the entire way with Diana's point, because a doctor is not only a doctor. A doctor is many other things and so has other interests. I understand that.

But Professor Rothman this morning told us how medical education, medical practice, were being changed by the presence of so many more women who weren't about to be told it was a 24/7 calling, and that was evidently a good thing, I think, as far as I could tell.

But that didn't sound in some simple way like placing patient interest ahead of self-interest; it sounded more like kind of sorting out life in such a way that I looked after my own interests. But it was evidently a good thing.

So I just think that this whole talk about interest is not clear. It's muddled by, as I said in my comment in the earlier session, the kind of language of altruism that hasn't been sorted out, hasn't been thought through carefully. And we're not going to get anywhere until we get clearer on what that is. That's one sort of comment. And until we can do that, I don't know what it means to make patient welfare - give primacy to it. I just don't know what it means.

The loss of trust, which is evidently sort of the primary problem - and it may be. I don't know. I haven't done sociological studies. Maybe it's the loss of trust in physicians. But what's the evidence for thinking that the primary reason for the loss of trust is some tendency of physicians primarily to pursue their own commercial interests? I mean, maybe there is evidence, but I haven't seen any. What is it?

My hunch would be that specialization has a lot more to do with it, in the fact that you don't deal with the same physician over time and therefore don't have the same kind of relationship that leads to trust. Or it might be - I mean, if I found out that my physician was thinking that one of the primary aspects of his profession was a commitment to social justice, I might start to worry that he was going to think about somebody else's needs a lot more than mine, and I might begin to lack trust in him.

So that these several claimed aspects of professionalism just don't fit together for me. And then finally, it may be that we need to restructure society in fundamental ways. And probably you always need to restructure society in fundamental ways. But we've got to have arguments about this, and about how it's supposed to be done, not just general claims or assertion. I just don't see where we as a Council are going to get anywhere with just some sort of general assertion. I mean, the same thing is true with respect to education. There is an enormous disparity between the wealth that we have there and the distribution of it. No doubt it should be altered in some way. But how to go about that - I mean, I can't imagine that just asserting the fact is very helpful.

So I just think that there are a lot of particular examples we've been given that are persuasive and compelling, but I don't see that theoretically we're getting anywhere or making progress towards something that - well, that we'd have a contribution to make about it.

CHAIRMAN PELLEGRINO: Dr. Bloom.

DR. BLOOM: I'll try to be brief, because I think we've had three very eloquent, well reasoned and clear discussions of what the issues are in re-establishing a professionalism in the medical profession.

But it seems to me that if you listen with a filter for what is the recurrent element that each of the three speakers spoke to, it's the healthcare system that is causing the problem, and frustrating the young physicians and developing the cynicism of the maturing physicians, and in beating down

those physicians who have dedicated their lives to taking care of the poor.

The system is overwhelming the professionalism that was there at the start. And unless we do something about the healthcare system, it's going to be like the old joke about the honor system. The administration has the honor, and the students have the system.

In this case, society has put us into a position where we cannot do what we think is right. And if we don't stand up for telling the public that what we're doing is pulling the wool over our own eyes by tolerating a system that will not allow us to promote the health of our countrymen, we're not doing good service.

We're in an election season. Healthcare has to be on the agenda for the nation as a whole, and this Council ought to make statements about the hypocrisy of our healthcare system. We have to acknowledge not only that certain sectors do it better than others, but that we're not allowing the huge investment we make in healthcare to contribute to health. We spend more of our gross domestic product on health than any other nation in the world, and yet we rank very poorly on the health of our country.

That, it seems to me, along with the .789 in Jordy's talk about access to care and universality of care and quality of care, is a much bigger issue than trying to give pep talks to residents to maintain a professional attitude in a system that we have tolerated for 25 years that we know is going in the wrong direction.

CHAIRMAN PELLEGRINO: Thank you, Floyd. Dr. Schneider.

PROF. SCHNEIDER: First a quick word on trust. The trust that patients have in their physicians remains quite high, possibly because patients have no choice but to trust their physicians. The trust in leaders of medicine has gone down.

Of course, the trust in every human being in the United States has gone down - every profession, every business has lost trust. And if you ask people, "Do you trust people generally?" they will say, "Less than I used to."

So, I think that looking for reasons in medicine for the decline in trust in medical leaders is probably not a very fruitful activity. I confess that I have tried to read these materials and some of the supplementary materials that were referred to in the materials, and I've listened to the conversations this time and last time. And I feel as though I am swimming in cotton candy.

This conversation is being held at a level of such abstraction that I have no idea what's going on. I passionately agree with a lot of the things that people have said about how wonderful the ideals of medicine as a profession can be, and for that matter, of lots of other professions.

And yet I find the conversation taking place in terms of this word "professionalism," which has no meaning at all. It is used by every group that wants to be better regarded and better compensated. And it is used as a way of fighting all kinds of battles without actually coming to grips with what's actually going on.

In search of guidance, I read the Physician Charter, and I have to say that I found it absolutely incomprehensible. It, too, is phrased at such a level of abstraction that you can't disagree with anything in it, but you can't tell what anything in it is actually going to mean when the rubber hits the road.

I find myself confused because the conversation is at such a level of abstraction that I don't know what the actual evidence is that things are so bad or things might be so good.

I read the description of what life is like in medical schools because of the abominable way that many faculty members behave, and I looked to see what the citation for that proposition was, and it was another article that didn't have any actual evidence, but just said, "Things are terrible." So I don't know what the actual empirical dimensions of things are.

Then we have been talking in terms of another set of abstractions, this abstraction about the contrast between commerce and professionals. And it seems to me that that discussion has been made almost exclusively in caricature.

I know lots of business people who have better ethics, a better sense of responsibility, and care more for their clients than a lot of members of professions do. And a number of people have said about professions that they have behaved in ways that have caused them to lose trust.

I do want to say about the trust, remember that in 1909 Bernard Shaw said, "The medical profession has not a high character; it has an infamous character." In 1978, a political scientist wrote, "There are widespread complaints against the medical profession on the grounds both of failures in the realm of service to the public and of defects with regard to effective self-regulation. This is 1978, remember. "The public dislikes the way physicians often seem to be concerned more for science than for caring, to have turned their means into ends, to have become authoritarian and unresponsive," and finally, "to care too much about their money income."

So, this idea that somehow, if we just abandoned this bad thing that is called commerce and went to this good thing that is called professionalism, then all would be well, I find operating at a level of caricature that I don't think is very helpful.

I also think that it's important that we be more precise about the historical moment and about something that I think we have almost not heard discussed at all, which is the role of the organized profession.

And I keep saying "profession" instead of "medicine" or what have you, because I regard all professions as conspiracies against the laity, as Shaw said some years ago. I know of no profession that runs itself in a way that we ought to admire.

But let me talk more particularly about the role of organized medicine. The definition of professionalism we hear is a definition that talks about the importance of service to others and to the welfare of the patient.

But organized medicine, which ought to be more interested than in anything else in seeing to it that all Americans actually have some way of acquiring medical care - organized medicine has fought proposal after proposal after proposal for some way to fund it. They, you remember, opposed Medicare and Medicaid. They called it socialized medicine.

And organized medicine continues to play a role in these professionalism issues that seems to me to be highly destructive. The conversation that we're implicitly having seems to me to be in large part about managed care. When we talk about how hard it is now to practice medicine properly, I take a lot of that conversation to be a conversation about managed care.

And it may well be that managed care is a dreadful thing. But let's remember how we got into managed care. We got into managed care because after Medicare and Medicaid, the fee for service system got more and more out of hand, and it became impossible for us to feel that we could continue to pay for medical care.

And in an attempt to try to control those costs, we moved to managed care. It may well be that managed care isn't the right way to do it. But the difficulty that I have here is the difficulty that I have in many aspects of the way that organized medicine has dealt with these problems.

Organized medicine has not come up with a good substitute for managed care. It has said, "Things are bad. Stop hassling us." Organized medicine has not come up with a good way of providing care for poor people. It has just said, "We're against every proposal that you have put forward."

I not only looked at the manifesto for-that's not a good - the charter for medical professionals, I looked at the article about the alliance between society and physicians, which amplifies the charter. And it seems to me to carry on in this vein.

It says, "Yes, we're in favor of all of these altruistic things, but you've got to remember we need to have enough salary or enough income so that we're not unduly tempted." I find that deeply embarrassing.

Right now, house-sitting for us is one of my neighbors. I live in a working class community, and my neighbors would feel very lucky to make the average American household income, household income, not individual salary, which is about \$50,000.

And my neighbor is sitting in my house, and I expect him - he seems to be operating under much more temptation than a physician has. I expect him not to steal from me. And I think we expect the maids of this hotel not to steal from us. And I think that it's clear that there are people who live under much greater kinds of temptation.

So to begin this discussion by talking about the need to pay doctors enough that they're not tempted to behave unethically strikes me as very troublesome. The alliance paper then goes on to talk about in extremely colorful terms how impossible the legal system has been, and it talks about the need for

doctors to be able to maintain individual and professional autonomy.

If you look at that through the kind of historical lens that I'm talking about, what it looks like is another attempt by a profession to say, "Do not regulate us, but let us continue to control ourselves."

Now, that leads me to what seems to me to be one of the most egregious failures that all professions display, which is a failure to deal with their incompetent and unethical members. It is absolutely plain that no profession I've ever heard of is willing to take that job seriously.

And one of the problems I have with the discussion we've been having and with the charter of professionalism and all the rest of it is that nobody has ever talked about how it is we're actually going to enforce any of these ideals.

We are supposed to be moved by the loftiness of the ambitions, and I am, but I want to know how it is that we're actually going to deal with people who don't do the right thing.

That leads me - and I'm coming to a close pretty soon - that leads me to what seems to me to be a temptation of all professions-it happens in law - to say, "Oh, my God. Things are terrible here. What we have to do is to tell the medical schools and the law schools that they have to educate people better and all will be well."

The first thing that's wrong with that is that I don't think I'm going to live long enough to have all of the unethical doctors and lawyers pass through the system to be replaced by the newly educated doctors and lawyers who understand how to behave ethically.

The second problem I have is that it is just grossly implausible that any kind of activity in a professional school is going to make professionals behave well if they get out into a world in which bad behavior is beneficial to them and good behavior is costly.

If there is one thing that psychology has discovered about human behavior, it is that character matters surprisingly little, and that the circumstances in which you find yourself matter a great deal.

I'm sure you all know about the Milgram experiments, where they took perfectly normal, decent residents of New Haven and induced them to, in the understanding of the research subjects, to give terribly painful shocks to apparently perfectly innocent people.

And this kind of experiment has been duplicated all over the place, and it represents a very standard understanding that you can make people virtuous in character all you want, but that their actual behavior is going to be very strongly influenced by the circumstances in which they find themselves.

Let me suggest one way in which education, if it really wanted to take professionalism seriously, might do it. And that is by disciplining their students. If it is true that 97 percent of the people who enter medical school leave with MDs, then it is clear that that is not what they are doing, that they are not taking this seriously.

And I'm certainly here to tell you that law schools do not deal with their inadequate students in any way that suggests an actual interest in encouraging professionalism or in deterring misbehavior.

I actually spent last semester visiting at the Air Force Academy. And one of the interesting things about it was that that is an organization that actually does care about professionalism - being a military officer being one of the original professions.

But they believe that in order to make education effective in encouraging professionalism, you have to make that a primary activity. So the motto of the Air Force Academy is "Integrity first." "Service before self," second. "Excellence in all we do," third. But integrity comes first.

And "Integrity comes first" for them means that if you lie, cheat or steal, or tolerate somebody who does, you throw them out of the Academy. And it is by that kind of clear statement that you really mean this and you're not just adjuring them to behave better that you have any hope of having education make any kind of difference.

So I wind up truly hoping that if we move in some direction that we speak with enough concreteness and clarity that we do not become one more statement of high ideals.

CHAIRMAN PELLEGRINO: Let me mention that we're reaching the end of our time, and what I will do is the following. Peter, obviously, you make your comment, and if anyone wants to make one more comment, then we'll have a break and we'll come back and give our speakers an opportunity to respond.

And I don't mind cutting into time allotted to me. So don't worry about that. And I'm sure you're not worried about it anyhow. You wanted to get on the list, Dan? Okay. And we'll open the list again when we come back. But I'd like Peter to make his comment if he would, and then if you don't mind, we'll take a break and you both respond.

Are you in a rush?

DR. COHEN: I've got a 6 o'clock flight.

CHAIRMAN PELLEGRINO: All right. We'll give you a chance to respond, if the group doesn't mind. Peter.

PROF. LAWLER: All right. I'll make this as brief as I can. I certainly can't follow that. And I'm not an M.D., and on all of these issues I don't have a strong opinion. I am though, in the profession, such as it is, of political science. And here are some irritating words that have snuck into the profession of political science, coming from academic administrators.

"Civic engagement," "social justice," "social activism." Now in the opinion of deans and other administrators, the most important thing in political science is to inculcate in students passion and purpose. In other words, get them out there being all activist about everything in some sixties manner, without asking the question, "Do they have any idea what they're talking about?"

So actual education is subordinated to activism and engagement. So when I think about a physician, I wonder how much this really has to do with the job of a physician. In my county - quickly-we're a regional medical center. We have more physicians than any other county in the country per capita.

Not only that, studies have shown that physicians in our county enjoy the highest standard of living, relative to the local standard of living, of any county in the country. So our physicians are as happy as physicians can be nowadays.

As a result of that, many of our community leaders are physicians, and they do many admirable philanthropic things, as Dan does and as so many of our-as Ben does, and the other physicians on our Council do. But I'm not sure they do these things as physicians. They do these things because they're good guys, they make the big bucks, and have some extra time. I'm for them doing this.

And some of them are involved in politics. Some of them get elected to office. They have all sorts of political opinions. But their political opinions are not particularly good because they really weren't trained to have good political opinions, nor would an extra course in their medical education really have helped out there all that much.

In fact, many physicians in my area disagree with many of the things that have been said here. They are radically libertarian. They believe that the problem of access could be solved through a lot more market, not less. I tend to think they're probably not right, but I don't think they really know whether they're right either.

So our physicians have all sorts of political opinions. They're all over the map. But some of the writing - and I think in a certain sense some of the presentations-suggest that physicians as physicians have a particular conception of social justice that unites them together in this particular agenda they should push together as physicians. I just doubt that this is really so.

DR. FOSTER: I just want to make one sentence in defense of physicians and residents. I've just come off the wards at Parkland Hospital. I think that this crisis in professionalism is at least something that I don't see working on the wards. I think the students that we have now are enormously admirable, both in terms of their talents and dedication to science and in their kindness in taking care of the poor.

And I'd say one other thing. Almost every one of the - I would be happy to have almost every one of the senior residents at Parkland Hospital take care of me now, or my family. I just want to say a word about - I don't think that - it's just not the picture I have of the crisis of loss of altruism or anything. And I'm only talking about one place, and maybe you might think that I'm too much of an optimist. But I just got through with this, and I'd let them take care of me right now.

CHAIRMAN PELLEGRINO: Jordan?

DR. COHEN: Well, let me make a few comments, if I could, in response to some of the things that have been said.

Let me start with Dr. Carson's comments. Two things I want to comment. First of all, I think your notion about the selection of students is right on target, as I tried to mention. And one of the things I didn't mention that I think is important is the way in which schools project what they're interested in to prospective students.

And I think there is altogether too much - the perception is that we're interested only in grade point average and MCAT scores and not interested in these issues of character and commitment to service and what have you.

As a consequence, I think - and again, I have no evidence for this but this is my strong perception - that a lot of students who I would very much love to see in medicine would even be more impressive to you, Dan, than the ones that you are now dealing with, never even choose to apply to medical school because they don't think that's what we're interested in, that we're interested more in what's in their head than in their heart.

So I think one of the jobs of medical schools is to be more explicit-to the degree that they believe this, which I think they do-but to be more explicit about what they really are looking for in applicants, that these are as important characteristics as long as they have the scholarly and intellectual capability to meet the challenge.

And several of the points you made and several of the points I think that Dr. Meilaender made as well I think relate to this issue I ended my comments with, namely, that to the extent, again - and you may not agree with this; from your comments I'm not sure you do - that the public does have a stake in doctors and the profession adhering as best they can to this ethic of service to the public.

That to the extent that there is a commitment to that kind of service-oriented value system, the public gains a great deal. In the absence of that, there would be much to be lost. Now, you either accept that premise or not.

But if you do, then it seems to me that one has to take cognizance of the fact that there are a number of things, as I tried to indicate, and which that alliance paper spells out, that the profession cannot grapple with unilaterally. It requires some kind of interaction with the policymakers or the lawmakers in order to address the access issue.

We can't solve the uninsured problem as a profession. It requires that we convince the policymakers that they've got to get in bed with us and lead with us and solve it. We can't behave the way we want to behave in the absence of access to care, in the absence of the ability to do the quality of things and all the other things I mentioned.

And again, on this topic, Dr. Meilaender, I'm really sorry that I think you misread that aspect of the alliance paper that spoke about physician payment. It's not that we're looking for more money; it's the mechanism of the reimbursement system that is not properly aligned.

I wouldn't have any problem with there being no more or even less money available for physician services. But the way it's currently committed to the profession, it doesn't reinforce the attitude of patient interest primarily. The fee-for- service system in my view is antithetical to a profession that truly is acting in the interests of the public and patients.

You can't expect doctors, particularly with the disparity in the fee-for-service as it currently exists, to avoid that temptation. It seems to be more than one can honestly expect even of a highly motivated physician, to adjure self-interest when they're faced with that kind of temptation.

So that's the point that I was trying to make there, not that doctors want to make more money. It's just that the mechanism of payment is not properly structured to deal with these issues.

CHAIRMAN PELLEGRINO: All right. I think we'll take a break until 4:20, and then return and give Dr. Leach a chance to respond, and further questions you may want to raise or contribute.

(Whereupon, the proceedings in the foregoing matter went off the record at 4:10 p.m. and went back on the record at 4:25 p.m.)

CHAIRMAN PELLEGRINO: What we'll do from this point on is ask Dr. Leach if he wishes to respond. If others of you have other questions, let's not repress them. We'll continue, as I think the discussion is going in a very - how shall I put it - interesting manner, and we should continue it and try to explore some of these issues further.

Don't worry about cutting into my time. I'll get a few one-liners in somewhere along the line.

DR. LEACH: Thank you very much. I'll be brief. I have to, not for lack of interest, but because I have a plane to catch. Something very practical that you've been calling for has occurred, and I have to catch my plane.

I would encourage all of you to listen to Dr. Carson. I agreed with everything he said. He mentioned information systems and what patients would do when abundant reliable data became available. I've thought about that a lot. And it seems to me there are three reasons why a patient would continue to go to a doctor.

One is that unlike the computer, the doctor shares a human vulnerability with the patient. Both are going to die; both are going to suffer. And that's comforting when you're sick, to be in the presence of a fellow human. If that's true, then the educational programs should encourage one to become more fully human.

I think a second reason is that I have a friend, David Stevens, whose wife is a musician, who is a physician. And he woke up with severe pain in his joints and a little rash in his popliteal fossa. His wife, with no medical knowledge, got on the computer and discovered that the rash on his popliteal fossa looked exactly like Lyme disease.

So, totally naive, she said, "I think you've got Lyme disease and we should get some doxycycline." And she marched him to the internist and walked in and said, "David's got Lyme disease. He needs doxycycline."

And the intern said, "Well, that's very interesting. We'll have to do a few tests." And she said, "Tests are not helpful in the early phases of Lyme disease. He needs doxycycline." And he got it and was cured.

Well, that reminded me of a second reason why people would go to doctors. "I think it's Lyme disease, but I don't know. Perhaps you've seen a case. Maybe you can recognize this pattern." So, in addition to training doctors to be human, we should train them to reflect on their practice, accumulate their experience, and learn how to discern early pattern recognition.

And lastly, if you're going to have your brain operated on, not everybody can do that or prescribe certain drugs and so on, and they would go to actually get that done. So those are three reasons why patients would continue to see doctors in the information age.

I think the system should acknowledge the importance of those three things and pay attention to them. Right now, you know, it is said that every system is perfectly designed to produce the results it's producing. And the system is producing the results it's producing. It's producing things we like and things we don't like.

So, the inordinate expense, the inadequate results, it's designed to do that and so it's doing that. Now, you could - perhaps it's dignifying healthcare to call it a system. It is so fragmented, it's not really a system. But the thing that we do call "healthcare" is demonstrating abundant opportunities to improve, that are going to require redesign. And perhaps some of those issues are important for this Council.

Residents became stressed, as did the whole healthcare system, when basically three things happened: one, because of DRGs, time was compressed. When I was trained, I had typically two weeks to get to know the patient, and that was all. It was a true relationship. Now they're in and out in a day and a half. And the resident's life consists of admitting, discharging, admitting, discharging, admitting, discharging, on a treadmill. It's a different lifestyle, one that challenges ethical principles. There's more to do.

When I was a resident, if you wanted to know how the patient was doing, you had to go and talk to the patient. Now you fill out forms to get tests done that are helpful, but it consumes all of the available time, and you don't talk to the patient. It's part of the system.

And lastly, there's less help. There are fewer nurses. So residents are doing more in less time with less help. And, in that environment we're trying to say, "Be ethical." It's a stress.

Someone mentioned, you make residents virtuous. That's not the way it works. It's educating virtue; it is taking what is latent and encouraging and allowing it to emerge. It's tapping into their fundamental human goodness and creating an environment that that happens. And I think it's important.

And lastly, I think this Council is wonderfully diverse. And there's a price with diversity, and that's

conflict. And vision is a physiologic hallucination. So there are billions of photons hitting my retina right now. I can't possibly process all of them equally. I would go insane. Based on my background and my experience, what I have discerned in the past is important or not, I scan a room and see things, and then there's a whole bunch of stuff I don't see, because I have not thought it important. As I heard your comments, I was reminded of that.

When two smart people who care about an issue are arguing, it's not that one is right and one is wrong; it's that both are blind. And this Council and your report is going to help do something. You have to honor and deeply understand each other's perspective, and that's, from my point of view, the work before you.

I have to go catch a plane. Thank you very much.

(Applause.)

CHAIRMAN PELLEGRINO: Any comments, questions? Robby, you look like you're about to ask one.

PROF. GEORGE: Well, I was struck, as I'm sure many were, by the powerful condemnation that Dr. Leach offered in his prepared remarks of the postmodernist view of life as denying any objective basis, denying that there is any moral truth.

And anyone who has spent any time in universities in the last couple of decades knows that that is not only a prominent view, but in very many places, almost an established orthodoxy from which dissent is remarkable.

Now, if Dr. Leach is right, and I have every reason to believe that he is, that this has an impact on how young people who are educated and socialized in our system, both in our high schools and colleges - because it's now filtered down into high school certainly - if he's right, that that has an impact on how people come to terms with the demands, the ethical demands of their professions, then it is a serious problem.

And it's not a problem that can be dealt with by professional ethics courses in medical schools or law schools or what have you. It's a socialization problem from the beginning. And what it does is, I think it - again, if Dr. Leach is right - it means that we're not going to solve this problem unless we take seriously the problem of a certain ideology having such powerful standing in the intellectual culture.

Now, I'm sure this Council doesn't want to get into the question of postmodernism and its ideological hegemony or anything like that. But it might be that anything else is really kind of tinkering around the edges or rearranging the chairs on the deck of the Titanic.

I know Dr. Leach has to be right, it seems to me, about this. You cannot preach to young people that there is no truth, that it's all socially constructed, that all we have are moral opinions, there's no such thing really as right or wrong on one set of issues, issues about sexual morality or drug-taking or the sanctity of human life or whatever, and then turn around and, with respect to questions of social justice or professional responsibility, there is an objective truth that is rationally accessible and which can be imposed on people if they are recalcitrant about living up to it in their professional lives. I mean, that kind of a mixed message just can't possibly work.

So I was very powerfully moved by what you said. It certainly resonated with my own experience with 22 years of college teaching and a few years before that in the universities as a student. But it does leave me deeply wondering whether our problem is not deeper than what can be addressed by any systematic shifting of systems and rules. That it's really a deep problem in the intellectual culture.

And I thank you for what was really powerful testimony in two senses.

CHAIRMAN PELLEGRINO: Thank you, Robby. Do I see a hand?

DR. HURLBUT: Do you have time for a question, or do you have to run to catch your plane?

DR. COHEN: Ask me your question and I'll let you know. No, no, we have a couple of minutes.

DR. HURLBUT: Just briefly. You talk about the outer leaves of the lettuce, and my question this morning is the same basic question. Is it possible that the role of medicine, the deep professional purposes, the star we navigate by, is somehow lost?

Is it because of just what Robby has affirmatively said, that because we were criticized for being overly paternalistic, we shifted toward relativism, that we gave up some of the longstanding principles of our code in the face of the rising social acceptance of practices like euthanasia, abortion, the confusions of modern biotechnology? I just - give me one minute.

I'll read something that troubles me very much, and I'm just putting this out. This is a quote from Margaret Meade, taken from a book called *The New Medicine* by Nigel Cameron. He says that at the time the oath was articulated - and there may have been a period of time obviously - that the practices such as euthanasia and abortion were common. These were accepted practices; they were not just considered evil, that there was a real revolution in the Hippocratic oath.

Margaret Meade, who is not generally considered to be a conservative Republican or whatever you want to say, she says, quote, "The Hippocratic oath marks one of the turning points in the history of man."

She writes, "For the first time in our tradition, there was a complete separation between killing and curing. Throughout the primitive world, the doctor and the sorcerer tended to be the same person. He with the power to kill had power to cure, including specifically the undoing of his own killing activities. He who had power to cure would necessarily also have the power to kill.

"But with Greek Hippocratism, the distinction was made clear. One profession, the followers of Aesculapius, were to be dedicated completely to life, under all circumstances, regardless of rank, age or intellect. The life of a slave, the life of the emperor, the life of the foreign man, the life of a defective child."

And then she goes on to say, speak of this as a "priceless possession which we cannot afford to tarnish." Now, I just threw that out because, as Ben articulately said, we are facing challenges, projects like fetal farming and so forth. If we're really going to get down to questioning professionalism, it seems to me we have to look at - you said it very directly. Is it deep hunger to return to classical medical values?

Is it possible that some of the outer layers on the lettuce are modern aberrations of understanding of what professionalism really is, and that the core problem in our profession may not be commercialism, self interest, or all of these things, but that we have lost the guiding principle that is fundamental to our profession?

I really didn't put that out with an agenda of assertion so much as a question.

DR. LEACH: I think that's exactly the right question. And I think the substrate of medicine, seeing people when they're sick and vulnerable, you either support human life and its dignity or you go into some other profession. I mean, it is a fundamental human activity.

And that is why I think the great strength in response to this - I don't know whether this is a crisis or not. I think that there's been erosion of some traditional values. Young people and faculty live in a postmodern world. It has had a set of assumptions that have not always been carefully examined.

Having said that, I do not think this is a political argument, you know, for abortion/against abortion. I think that justice and mercy kiss. And I think a good doctor defends life and has mercy and has great compassion for the patient's circumstances and doesn't compromise or increase the patient's vulnerability by a political agenda. It's deeper than conservative or liberal.

And to me, yes, I think - and of course, this is a horribly mixed metaphor - the lettuce leaves are brown, a few of them. It's not strip them away. The potato may or may not be sound. That is the question. If the potato is sound, we will get through all kinds of this and many other changes in the forms of medicine. If the potato is not sound, we're dead.

And so to reinforce that at all levels of the educational system and the practice world means you have to have an understanding of what a healthy human set of values looks like. And that has to be the organizing principle, as you adapt to the thousands of unique patients that come with particular problems.

You can't look that up in a rule book. You have to have a good heart to manage that. And that's what professionalism is all about.

CHAIRMAN PELLEGRINO: Further questions?

DR. ROWLEY: Would you comment again on one of the things that Ben said, which was that

physicians are trained to be emotionally withdrawn, or detached from patients, and that maybe this is a bad thing? I'd be interested in your views on that.

DR. LEACH: And don't forget that he also said he could never do that. Which I think is the mark of a good doctor. But it is true, and I think - I mean, it began long before Osler. But Osler said equanimity is what you have to offer patients.

So when the world is coming to an end and everything is panic, if a doctor can stand in full equanimity, which does require a wonderful honoring of both arms of a paradox - detachment enough to have equanimity, engagement enough to actually help. And you cannot dishonor either arm of the paradox.

But you do have to hurt people sometimes to get them better. I mean, when Dr. Carson operates, it hurts. I wouldn't want an operation on my brain.

DR. CARSON: We have anesthesia.

DR. LEACH: But then so you have to be able to say, "Yeah, I'm going to cut your head open, take the bone out and put it - yeah, I'm going to do all of that." And you have to do it well, and you have to do it in a balanced way. And so you have to be a little detached to do that. You wouldn't do that with your neighbor on a Saturday afternoon.

But you also, if you're a good doctor, don't let the detachment get to the point that you don't give a damn. You constantly are supporting the needs of the patient.

CHAIRMAN PELLEGRINO: Again, thank you very much for joining us. Well, there are a few minutes left.

DR. ROWLEY: Well, I was just going to say that since this is an area in which you have thought about a great deal, speaking for myself, I would really like to hear what you have to say on the issue. And I don't think you should cut your remarks short. I am perfectly happy to go to dinner later or whatever.

SESSION 4: THE "CRISIS" IN THE ETHICS AND PROFESSION OF MEDICINE: SOME CONCLUDING REFLECTIONS

CHAIRMAN PELLEGRINO: Well, I won't take all the time. I mean I will not give the remarks that I had in mind. But I will make a few -

DR. ROWLEY: The whole point of what I said was that you should give the remarks that you had in mind. And just go on.

DR. KASS: I think Janet is right, Mr. Chairman. I would second what Janet said. I think we really need to hear it.

CHAIRMAN PELLEGRINO: Well, let me make a few comments. First, all crises are not bad. If you will remember the dictionary definition of a crisis, so far as medicine is concerned, it has to do with an old observation we used to make - I think Dan even may be too young for it, but I'm not - of the patient who developed pneumonia, and we didn't have any antibiotics - I date back before antibiotics - and the patient would go through a crisis. And the crisis would mean either death or recovery. And we would always wait for the crisis somewhere between seven and ten days with pneumococcal pneumonia.

I don't know whether you will decide that medicine is in crisis or not to respond to Carl's question of last time. But let me give you a few crises in medicine, just to raise some hope in this discussion, which has had a lot of - some dismal qualities to it with respect to the future of medicine.

The Hippocratic Oath, which has been mentioned, arose at a time of crisis. The Greek medical profession was in total disarray. They were considered mostly quacks and money grubbers. And the Hippocratic physicians who created the Oath stepped back and said, "No, we don't want to be like those people." And they developed an oath of commitment.

Let me give you two or three more of those, and then I'll move on to what I want to say.

A similar situation occurred in the first century A.D. when the word "professio," the first use of the word "professional," which we've been throwing around here today, was made by the physician of the Emperor Claudius.

And he talked about "professio," the Latin word, strict word, of a commitment to what? The Hippocratic Oath. And he made it in a treatise which was dedicated to the fact that giving medication to people would be in their interest, but he justified it in terms of the profession of the physician, the promise, the declaration - that's the etymological meaning of the word - was in fact to act in the best interests of the person. And at that point, people were not doing it. So that was a reform.

1803, the reform of Thomas Percival - when the physicians of the Manchester Infirmary were in a state of tremendous strife with each other - the Thomas Percival Code, which is the basis of the AMA's code.

In 1857, the medical culture in the United States was in a terrible state of distress, with the same kind of nonsense that was going on with the Greek physicians, and we got the AMA Code of 1847.

You're all familiar with 1910, when Simon Flexner had the comment on the dismal state of American medical education, 450 schools, and the conception of scientific medicine was a single microscope, which usually wasn't in very good operating condition.

I think we're in a similar situation now, where the profession once more is in a state of confusion and identity in its relationship to society, its patients to itself, and so on. And I'm hopeful, can you imagine, in the face of all of this, that we may get another kind of reform.

Professionalism is one of them. I do not think the Physician's Charter is the answer. I think the Physician's Charter is admirable. It describes a series of characteristics, of attributes - ten of them, as a matter of fact - which we should have. But unfortunately, it is ascriptive, it is descriptive, it is not argued. And medicine is at essence a moral enterprise. It may not be conducted that way, but there's no way of avoiding it.

And let me then pick up that theme and carry it a little bit further in relationship to what is happening. Now, you will find a lot of this in the paper I submitted to you, and I don't want to repeat that for you.

But fundamentally, I think if we are ever going to understand what's happening, it's going to have to be in terms of what makes difference in medicine. What kind of human activity it is which makes it different from other human activities.

Not that other activities haven't the same kinds of dimensions of morality put on them, but in medicine they are specific. And that goes to the fact that each and every one of you is going to be on the gurney one day. And I'd like you to put yourself in that position, if you would. You're on the gurney.

You may be healthy now, but I assure you, I'm sorry to say it, you're all going to be lying flat. And there's something about the horizontal position as opposed to the upright position that I've discerned in 66 years of medical practice that makes a difference in the way you look at the world.

And so I've concentrated in my whole notion of how medical ethics has a special characteristic, which people have been pleading for, it's related to what will never change, as far as I'm concerned. When you are on that gurney, you're no different than the sick patient Hippocrates had, than the sick patients we have today, or, I can assure you, when you get on the starship to Galaxy 999, it's going to be the same. You're going to be dependent, frightened, anxious - each and every one of you, no matter how intelligent, no matter how courageous you are, you're going to be in need of help. I use the word "healing" without apology.

You will need healing, "healing," being made whole again, which is what the Anglo Saxon word means. Whole again to the extent that we can do it, obviously. Not completely, but to try to repair, help, care, and when we can't cure, to care, to comfort. You're going to need that.

Now, in that existential state, I the physician come to you and I say, "Can I help you?" "What can I do for you?" What are the expectations you have when I do that? You have at least two, I feel, and I think you wouldn't disagree with me on that. One, that I'm competent, or the whole darn thing is a lie, my offering to help you, to heal you.

And the second one is that I'll use it in your interest and not my own, and I won't exploit you. Now, you will say, "Well, this is terribly, terribly fundamental. It's obvious." It's so obvious that it's painfully the thing that's most frequently missed.

Because, profession - go back to that word "professio" of Scribonius Largus and those before him, that act of profession is a promise, a public declaration, in terms of the Latin etymology of that word, which is still important, that I have the knowledge and I offer it to you, and you have the right to expect me to use that in your interest. And that is the bond of "professio." That's what a profession means in medicine.

In law it's another thing. In law they come to call and they're looking for some repair of justice. And he promises, too, to take their case. The minister deals with this. So what I'm saying is common to other professions.

I'm not expecting uniquely to medicine, except that in medicine we have the most intimate of human relationships, except those of husband and wife, which you mentioned. And friendship, perhaps. But nonetheless, one in which you must bare yourself. You've got to take your clothes off. You've got to bare what's going on in your mind. You've got to tell about all the nasty functions of your body. That's a relationship that doesn't exist elsewhere.

Ben has it in one dimension of his life. I as an internist have it in most of them. I can't do what Ben can do to heal, but also, I can, on the other hand, fulfill that compact. So it's a covenantal relationship. And therefore, I think the obligations of medicine arise from that.

Fidelity, trust, that's being a professional. Competence, that's being a professional. That's why those adjectives are listed. But I find it unfortunate they're listed as an answer to the problem by ascription, by assertion, without moral argumentation. So I'm looking for a moral foundation for, if you want to say, re-professionalization.

I don't like the term "professionalism." To me it has a connotation of belonging to a group, a loyalty to the group, a certain amount of elitism that we are professionals. I want to say the professional is the one who makes an act of profession to another human being to act in something other than his or her self-interest. And de-professionalism means a default of that promise. It means failure to keep that promise, and that's where the difficulty arises.

So that when you do come to the Botox dermatologist that was mentioned, that's really a failure. Now, therefore, from my point of view, what can we do? This is what you're asking, how we can change this? I don't think any program is going to change it. I don't think any system is going to change it.

I believe, with those of you who have raised questions about an educational program, yes, it's useful, raise sensitivities, et cetera. But I have been teaching for 65 years to medical students, and so far as I'm concerned, to learn something about this in the first two years of medicine is hopeless. It has no connection for them with reality. Third and fourth year it begins to impinge on them. And the residency is when it really, really happens.

Now, I don't want to go into all the details of how one might teach it. I have to shorten my comments. We are at 5:00 o'clock.

But I want to summarize by saying we have not, in today's discussion, gotten to the core, which is the human relationship, the very intense human relationship, between someone in this very vulnerable state, this exploitable state, eminently exploitable state, who has to come to another human being who declares that he or she has knowledge to help them, invites trust, pleased, obviously - whenever you're cornered, we're all pleased - to have Jordan come and put those words down.

But I mean those words. And all of those are charged with moral obligation. And what I would argue is that the obligations to the profession are entailed, if I can use the philosophical sense of that, entailed by the reality. So I'm seeking for the internal morality of medicine. Not that which is attributed to it, but entailed by the actions we take, by the way we live at the bedside.

Just one final comment. Don't jump to the conclusion that that means that I am ignorant of the social responsibilities. But I do think there is an order of priorities.

When I'm locked to you in that covenant of trust, when I said, "Can I help you?" that's a covenant. It's something more than a contract. It can never be a contract. How can there be a contract - I'm saying this to the lawyers - between two people who aren't equal? Not unequal as human beings, obviously, but in their existential state.

When you're lying on the gurney, that's a different situation in which to be. It cannot be a contract. You say, "I want a contract." Well, what do you want a contract for? You want to be helped, that's what you want. I have promised to do it, having engaged trust, fidelity of trust - I won't go into all of

it.

That's why I talk about the virtues, the moral agency they talk about in general terms. It has to be spelled out, spelled out in intellectual and moral virtues. Well, I don't mean to lecture you. I'm just pointing out the thoughts that were running through my mind as I heard the discussion.

I'm being perhaps a little critical, but I think what they're doing is very important. But it's not going to catch unless it's got a moral force, a moral impetus behind this, because we're in a moral relationship. And that's not the only one, and not limited to medicine. But it happens to be very acute in medicine. Think of yourself on that gurney, and then you begin to understand what I think about medicine and what we're committed to.

Ben, that's where I heard you say, "It's not my patient." That's right. That doesn't exist today, where you change at 5:00 o'clock and somebody else comes on. We know that has to change a little bit. But nonetheless, when I see someone, you are my patient and I am your doctor. Why? Because there is a certain covenant between us that can't be eradicated. You've entered into it. I can't wipe it out at 5:00 o'clock.

Well, let me stop. I don't mean to make a passionate plea for a profession which is having its problems today. It's having a crisis. I really hope that that crisis, and I believe that crisis, will emerge in another state of reformation. What it will be, I don't know. But I think it's going to be crucial for all of society.

Which leads me to a point that I do think it should be a matter of concern for this Council, because we are moving quickly from these moral questions unresolved to resolution in legislation and in policy. That's not the best way to do it. But let me stop.

Yes, Leon.

DR. KASS: The first thing to say is thank you, for that very articulate and moving account, and also for the paper which we were given to read which represents, for any of you who know, Ed's work over the years. It's just a distillate, a wonderfully rich account of the medical profession, beginning phenomenologically, what it is to be sick and what it means to offer the helping hand.

And I have to say, I don't dispute the importance of the other things that we've been discussing, either at the last meeting or the earlier sessions of this meeting.

But this does seem also to me an irreducible starting point for thinking about, not professionalism, but thinking about the medical profession and how it is healthy and rightly practiced. It seems to me right to begin phenomenologically with the relation of the sick and the healer who offers the healing hand.

It seems to be right to emphasize, at least to focus on the question of what is the good to be sought. And you and I might differ about how many of those four levels of good operate and in which way, but that's a family quarrel.

To put the teleological question, what are you trying to accomplish here? What is the goal? And therefore, in relation to that, what are the, not only what are the intellectual skills that are needed, but what kinds of traits of character and what kinds of powers of discernment and judgment - you call it "prudence," I think, rightly - are required to fulfill the implicit, and maybe even explicit, covenant that once upon a time taking the Oath might have meant publicly, and which is tacitly present in each doctor-patient encounter, even though no one has to say, "I hereby profess medicine, and all of those things that go with it."

I think this is the first paper that's seemed to me to put the center where the center belongs. And I guess - I mean, I've got a lot of questions, but maybe this would be useful: to invite some connection between these central matters and the kinds of things about which all of our other presenters have been speaking, where they seem to talk about the external constraints, and some of them not only external, but certain kinds of things having to do with the growth of medical knowledge and specialization, things of that sort, how one would begin to think about the preservation of this profound understanding of what it means to be in the healing professions in relation to these kinds of constraints that make this difficult.

You say that certain kinds of virtues are entailed. Well, they don't automatically follow, if by "entailed" it doesn't mean that if you have the covenant, you necessarily get the virtues. It means if you want to fulfill this covenant, you will need them.

And the question is, how in the present age, under these circumstances, should we begin to think about making this view of the profession vivid to the rising physicians, this view of medicine vivid to them in the face of all kinds of other things that suggest, and not wrongly, that there are systematic constraints, there are systematic deformations, there is the question of access, there is the question of distribution, there is the question of specialization, there are the deformations that the reimbursement scheme produces, of how much time you can spend finding out what's going on.

So, for those of us who like this, how do we begin to talk about this in relation to those things which are the most common and loudest complaints? If I understand you - and I'm sorry to go on so long, but I think this is really very important - you seem to be saying that there seems to be an insufficiently clear understanding within the profession itself, or insufficient articulation of what's tacit to the profession itself, of this kind of central core. And that if you wanted to begin a kind of reform or rejuvenation, you would begin with focusing on this.

These other people are saying, "That's not the problem. The problem is this can't go on except with that." And I guess I would invite you to try to connect this to the other conversations that we've heard.

CHAIRMAN PELLEGRINO: Thank you very much, Leon. As you know, coming from you, I particularly appreciate that. I do think this is - the problem is that we don't have clinical teachers anymore who really believe that the heart of the matter is at the bedside, and is with the sick patient.

Now, those who are not sick always say, "Well, you're always worried about sick people." But I go back to Hippocrates, the first line of his treatise on medicine, which says, "Medicine exists because people become ill." Simplistic statement. That's why we're here. We have public health positions. We have a responsibility to be involved with the larger prospect of what we do, in catastrophe and war and so on, we place the common good first.

But there's something, I'll use the word, "sacred" about my committing to you in that situation of dependence that you find yourself on the gurney. I don't know how to communicate that except to say it. I can teach it, at the bedside, because this happens with every encounter. You don't have to wait to have something designed.

Every encounter, whether it's very serious or not, I can tell you this, as a physician for a long period of time, that there is no serious illness that doesn't present a spiritual crisis to the patient. Spiritual not in the sense of religious, but a confrontation with one's own finitude, and that's the extreme of the vulnerability that a sick person can go through.

So I don't know what to say, Leon, except that happily, when I talk about this, just to raise you, give you a little more optimism, when I talk about this, at least 25 percent of the audience will come and say, "We're so glad you said it. Somebody needs to say it, to reinforce this. This is what we really want to do, but we can't do it."

And that goes back to the question of whether in fact the instrumentalities and organizations of society - we cannot escape moral accountability, is the other part of that relationship. You've made a promise; you're responsible, now, obviously, in varying degrees of mitigation of guilt. But that's not the same as being responsible for an effect on the patient which is deleterious or a violation. That's all I can say. Forgive me for the heartfelt presentation.

PROF. LAWLER: Well, sir, we have every reason to be proud of our Council members, because compared to our - I thought our speakers, although very eloquent and passionate, spoke too abstractly about psychological and moral distinctions.

And I'm not making this up, because almost everyone on that side of the table, on that side of the room, complained - Carl, the most at length, but also Gil and Diana. Whereas, your presentation, by contrast, was so rich and concrete, because you're using the full array of moral and intellectual virtues of Aristotle. This is a good thing. I'm all for this.

Nonetheless, someone might say, is it the job of the United States government to reconstruct or an advisory body of the United States government to reconstruct the ethics of the physician along Aristotle's moral and intellectual virtues?

Now, arguably, we might have snuck that stuff in in previous reports. But to do that straight out might raise some eyebrows. Because there's a reason why these fine men and women speak so abstractly. That's the way ethics is nowadays. That's the way ethics will tend to be in a rights-based society.

So this would be a genuinely radical challenge, not only to your profession but to all professions, in the way we think about ethics generally. And that would require that we all raise ourselves to your level of ethical expertise and detailed knowledge of Aristotle. So, I'm up for it, but it would be tough.

CHAIRMAN PELLEGRINO: Thank you, Peter.

DR. FOSTER: Can I follow up with that, and Leon's statement? I mean, let's say you think that professionalism is something that should be continued by the Council and some sort of a report brought from it. But one of the things that Leon mentioned was connections, and you just did the same thing, Peter, and so forth.

I mean, if you follow up on Peter's statement that if this is an advisory Council on the greatest bioethical, politically bioethical, questions facing the country and the Council is not fundamentally related to physician failure and professionalism and so forth, but has to do with the issue of a system that does not take care of its people - and two or three people have said this today. I mean, you're not going to have an answer to the delivery of healthcare and the coverage system.

But it seems to me that one way you could, if you didn't want to just come out and say that we don't have a solution to the problem, but we believe that the number one - and everybody in the presidential thing is talking about it - but that we think that this problem needs to be dealt with.

And one of the ways you could conceivably venture into that is to say that it's even having a huge problem on the professionalism issue of the physician, even there. Now, that's sort of a fake way to go at it.

But I still am worried about the fact of every - I don't know about you all, but the question that I get most often is what is the Council doing after the stem cell thing? I mean, for people who don't know what we've been doing. And they all say, "Why don't you say something about healthcare?"

It seems to me that in the professional, at least in my medical school and other places, that that's the question that I get most often. "Are you afraid to deal with this because it's political" or whatever, and I think that's a question that really ought to be addressed.

I mean, it would be of the seriousness that was involved with some of the other things that the Council has done. I don't know. I mean, the Chairman speaks exactly what I feel about medicine, and I think everybody here feels about that, too.

But I think Peter's point is sort of an interesting one. You've got two more years to go on the Council, and so you say you've spent eight years and you've never said one word about the issue of justice and mercy in terms of medical care.

If you live in - I'm lucky enough to live in Dallas, where we have a great hospital for the poor. The political community, both the commissioners' court, the counties, agreed to raise taxes. They want to raise \$1.2 billion for a new Parkland Hospital to take care of the poor.

I mean, that's a community that's - 1.2 billion is a lot. And the school district wants 1.2 billion for new schools. But I'm a little concerned, and maybe I'm the only one who gets that question. I got a lot of questions about our report on organs and so forth, about what are you going to do? It's now up to 97,000 people waiting, you know.

But I just think we ought to really address the question, are we going to avoid this? Now, the problem is that we don't have the expertise and can't get the expertise. And there are people, economists and everybody else who know far more about this.

I'm just thinking about a moral pronouncement about an ethical problem, a moral pronouncement, not a solution. But saying that the country - that we believe, as a body assigned to ethics, needs to address the question.

And we know that it's in the political thing, but let's say whoever comes in, it might be useful to - maybe because this Council was formed under President Bush, that anything we say, if it's a Democrat that's elected, doesn't want to have anything to do with what we say.

But I do think it would be worthwhile to have a sentence or two before we adjourn - and I know it's late - but whether we ought to look at that.

CHAIRMAN PELLEGRINO: If I can abuse your patience for a minute or two further on this issue. I also feel - I've been talking about the individual physician. I also feel that the profession of medicine as a community is a moral community. Now, a moral community is not a comment on how

they behave, but on their obligations.

And I think that while our first obligation is to the individual person to whom we've committed ourselves, is to that person, there are other levels, three more levels, in the way I develop it. Because we took an oath of committing ourselves to something beyond self interest when we took that Hippocratic Oath. That was the real essence of it, from the point of view I'm talking about. We did it together. We're responsible for what each other do.

We also in that have declared over and over again, in the preface to the AMA's Code of Ethics, that we are interested in the public. Therefore, the moral question comes up, what does a good profession or a good society owe the sick, those on the margin?

I think it is a major question, and I think the two go together. And I don't think we can consider ourselves moral professionals unless we are involved in some way. And again, I don't want to take you down the pathway of the things I've written.

But I do feel that that's part of the same kind of commitment that I'm talking about. Excuse me, Gil.

PROF. MEILAENDER: I'd just ask you to clarify something. Is your question what your profession owes to the sick, or is your question what the rest of us owe to the sick? Because, I mean, those are different questions.

CHAIRMAN PELLEGRINO: Yes, yes.

PROF. MEILAENDER: And it seems to me that most of the time we start with the question of what your profession owes to the sick and it turns into a question of what the rest of us ought to make possible for your profession to do.

And I think the rest of us do owe something to the sick, but I'd like to sort those questions out a little bit.

CHAIRMAN PELLEGRINO: You know, I take that distinction, but I think we should be leading, because of our close relationship to the human being in the existential state of illness.

I mean, that's what we're talking about when we talk about the healthcare system. We're not talking about a system. We're talking about a group of human beings who we know, and they're in that vulnerable state and not having access to what we think, out of mercy, or love, or whatever, we should be providing them.

I feel we have a moral obligation. A good society has a moral obligation. Now, if this group wanted to go down that line, I would love to go down that line and explore it further.

Yes, Gil?

PROF. MEILAENDER: If I may just push once more. I don't doubt that - I mean, I'm not sure about this "leading" metaphor. You asked us to put ourselves on the gurney.

CHAIRMAN PELLEGRINO: Yes.

PROF. MEILAENDER: Where we will all be someday, or someone else whom we love deeply. So, the question of, sort of, who leads in this discussion, whether the medical profession leads or whether we as citizens lead seems to me to be a worthwhile one, also.

CHAIRMAN PELLEGRINO: Oh, I absolutely do, because I think that when I speak to non-physicians or the general public on this, about the state of the healthcare system, I've said, "You get the healthcare system you want, and what you have is what you want in the United States until you change your notion of what the moral obligation of this society, if it's a good society, is to the sick, the poor, the on-the-margin.

Now, I sound like I may not even belong to this group, but that's my view of the matter.

PROF. GEORGE: Dan, let me say what I think the problem is, and perhaps you can respond.

There are moral positions that would dictate a policy, generally speaking, if they were adopted. For example, someone who, as a moral matter, believes in strict libertarianism, would want an entirely privatized system in which there was minimal government involvement, and would be prepared to tolerate any consequences, as far as the inaccessibility of some people to healthcare services, because of that moral commitment.

Another example would be strict socialism, where someone who just believes in that as a moral matter would say, "Look, we should have a government-run healthcare delivery system because that's just the right thing to do," and that would override competing considerations.

So, yeah, in those cases, if you happen to hold a view like that, then the matter is sort of dictated before we get into the details of the costs and benefits and tradeoffs and consequences of different opportunities, opportunities falling outside the bounds of the particular view.

But I suspect strongly that most people on the Council are like most people in the country, most people in the Congress, neither strict libertarians nor strict socialists. Rather, they are people who believe in the dignity of each and every human being. They do not want to see people suffering or deprived of healthcare when they are in need. But they're not committed to a moral conception that will dictate either a pure free-market system or a pure socialist system.

They would have that policy judgment be made on the basis of a whole lot of factors that certainly are considered within a moral framework, that includes a commitment to the dignity and profound worth of each individual human being, but where what's actually going to generate the conclusion would not be moral considerations just as such. There would be economic considerations, questions about what tradeoffs we ought to be willing to make, efficiency, just lots of factors that would have to be deliberated about, and about which reasonable people can disagree and about which, at least in some cases, I think wouldn't be a single uniquely correct answer.

They would be different people making different tradeoffs, or judging different tradeoffs differently, which means I think that the most we could say, unless we're prepared to go with a view that - a moral view, libertarianism or socialism or some other one that would dictate the answer independent of considerations of efficiency and tradeoffs and so forth. The most we could say is I think what you were calling a moral pronouncement. But it would have to be a pretty general moral pronouncement. And maybe this would be sufficient from your point of view.

But it would have to be something as general, it seems to me, as "We believe and we know our country is committed to the proposition that each individual human being has a profound dignity, that life and health are intrinsic and great human goods and should be respected and advanced in people and never directly harmed, that we therefore find it a very bad thing indeed that there are many, many, many people, a high percentage of people in the country, who do not have insurance to cover the kinds of needs that they could very well and often do experience. And this is an issue that's got to be dealt with."

Someone's got to. We have to do something about it, but we can't say, because we haven't gotten into the non-moral considerations where we don't have any particular expertise to say. No one can say whether it should be basically a market system, basically a government system, or some mix of the two; and if a mix of the two, at what level they are mixed.

And that leaves me wondering whether such a statement could rise above - and I'm open, so tell me if you think it can - could rise above the platitudinous.

See, I think when it comes to other issues, whether it's embryonic stem cell research or certain sorts of operations that are not medically indicated, Botox or what have you there, I think there are moral considerations that would lead at least some people, large numbers of people, to think we can resolve issues like that and have something important to say on issues like that, or at least marginal to relevant moral considerations before the public, to resolve the issue.

But with the general problem of access to healthcare, I don't see it as the same. Can it rise? Could we make a statement in your view, Dan, that would rise above the platitudinous?

DR. FOSTER: I don't know. I don't know. It might just be a platitude. I mean, I have no idea that it's a platitude. Well, we certainly can't do the methodology, you know, you could have a basic health system for the masses and a free system above - you know, there are ways that you could do it.

What we know is that essentially every developed country in the world has made a decision that they're going to take care of the people who are ill in the country. And we have, for a very long time, not had that thing. It increased, according to the latest census, another 6 million people who are uninsured. So I recognize that it might be a platitude.

But some very smart people, people like Seldon and people who have thought about this, and so forth, say that they think that it might be an enhancing thing for the Bioethics Council to say "This is a crucial problem to solve, and that we as a society need to do that." And it may just go off into the air. I have no idea.

I do think, and I don't have any statistical thing, I'm just telling you what people talk to me in the hall about, "Why have we not had a word about this critical thing?" And I think it might be worthwhile for us to say, if nothing more, that this is a crucial thing that needs to be dealt with. I mean, we've talked about enhancement, we've talked about all sorts of things that the bulk of the country are not. You know, it's an intellectual problem and it's an ethical problem.

So I don't know, Robby. I think you're, as usual, right on the mark. And I don't know. I just - because I just felt like after we've been talking, spending all this time on professionalism and so forth and so on, and it's impacted by these things, as Leon just said, and Ed said. I don't know.

We'd have to decide whether that's - the Chairman has said he thought it might - I think I heard him say he thought if we went down that road he would be enthusiastic about it. And just the fact that we - I don't know. It might just be steam. I don't know.

CHAIRMAN PELLEGRINO: I have Carl, Rebecca and Bill. And I just want to respond quickly, Robby. I fully agree, though on the methods of getting there and the intricacies of the system, there are going to be people of good will differing enormously. But I think if somebody could come out and say, whatever we do, it's got to be driven from ethics. The ethics drives the system and the economics, rather than the economics drives the ethics, that would be a tremendous advance. And I think that is appropriate for a group like this.

Now, let's hear Rebecca, Alfonso and Carl. And also, we're under the threat of having to evacuate this room at 5:30. (Bell sounds.) Wow. But if you can do it quickly, go. In that order - Rebecca, Alfonso and -

PROF. DRESSER: Well, I've got the same question that Dan gets quite a bit. And I've been asking that question for quite a while, and I know quite a few other people on the Council have. Why aren't we doing something on this issue?

I do think we've tried to say some things about it in the "Taking Care" report. But I would - as someone who was recently on the gurney, I have trouble saying it because of the reason why I was. Really, the description that you gave is so powerful. And I think it doesn't necessarily require highfalutin Aristotelian stuff, although that would enrich it, but it really would resonate with many, many people on a personal level and would take us down to the ethical, moral heart of the matter.

And then moving upward, it would be possible to connect certain problems that have been discussed, such as, some people, when they're in this very vulnerable position, all they can do is go to the emergency room and wait around in the corridor and suffer. And this is an ethical problem.

Now, we don't have to say, "And here are the nuts and bolts ways to fix it." That's what everyone else is talking about. But if we could boil it down to a core presentation of the harm that this does, I think that that could be powerful and useful.

PROF. GÓMEZ-LOBO: Repeating a little bit, I would ask Robby, what's wrong if it is a platitude? I mean, it is true that we cannot go into specific solutions, but platitudes are self-evident truth, all men are created equal, stuff like that, and need to be said precisely because they have not sunken in.

I'm amazed, for instance, when I talk with Europeans or with Latin Americans. They are simply amazed that Americans accept the fact that there are now - what is it? 47 million people without health insurance?

DR. FOSTER: The figure I remember is 46, but -

PROF. GÓMEZ-LOBO: Well, they said that it increased by 6 million. So I see a value in making this statement on the part of the Council, even if it is platitudinous. Simply for the reason that if it sinks in in the American public, if it reaches the Congress, you know, as a kind of moral pressure on them to seek a solution, or the next president, I see it as an important thing, even though it may be a platitude.

PROF. SCHNEIDER: I certainly agree that it would be silly to spend time trying to think about what the right kind of system would be, if only because I think the right kind of system is whatever system could be politically possible. Almost any system that achieves the end is going to be better than giving up on it altogether.

It may be a platitude, but it's a platitude that gets lost track of a lot. It gets lost track of by bioethicists, who rarely interest themselves in it. And it's a platitude that gets lost track of when we have discussions about how to reform the healthcare system, because those tend to wind up being

discussions about how this is going to affect my ability to work with my doctor, and so on.

So I think it is at the very least a platitude worth repeating and a platitude that's actually true.

DR. KASS: I have, I guess, mixed thoughts about this. The importance of the issue is, I think, evident to everybody in the room. The question is, what would the useful contributions from a Council like this be? When some of the bioethicists who are interested in this subject actually start to speak about it, they think that the grounds of the justification for doing something are self-evident.

We've heard "social justice" repeated many times. It must have been Peter, I guess, who raised some question as to whether people who use this as a shibboleth have thought five minutes about the very meaning of it. Because they seem to use it as a slogan as if it's sort of self-evident. And it seems to mean something like equality.

But it does seem to me it might be a useful thing to articulate the ground of doing something about this, not just the outrage that there are people who don't have care. But it's one thing if you go at this in terms of people have a right to something and therefore others have a correlative duty; it's another thing to say that healthcare is a social good and therefore it's a matter of distributing the social good, and it's a problem with distributive justice.

Neither, by the way, not that it matters, would be my preferred way into this thing. It's another thing to ask the question of how should a good society think about the needs of its least fortunate members, and do something not only for them but in a way for all of us?

And it does seem to me this isn't going to solve the problem. But there would be a way of articulating the different kinds of justification, and even to argue for the better ones, what we think might be better ones. That might be a contribution and a way of highlighting this subject, and not merely screaming about the outrage and quoting the numbers.

Or - and here I would underscore what Gil said - it's one thing for doctors to say, "We can't practice medicine the way we would like to practice" when - and this was 45 years ago, at the University of Chicago Hospitals, if the guy didn't have insurance in the emergency room, you hung up an intravenous and sent him to Cooke County. And that was a terrible thing for a young medical student to see. That's one way to answer the question.

The other thing is the question, if you really start from the good society and ask what it owes, you'd have to then think about what it owes in education, you'd have to think about what it owes in terms of public safety and various other sorts of things. And then the question becomes much more complicated.

So I do think there's something to be done here, if we're willing really to treat this as a question rather than as a slogan. And I think it would be very important, because the sloganeering only gets people's backs up.

And if we put some serious thought into this and try to articulate a principal defense for doing something, and a good diagnosis which does more than say, "There are these many uninsured," without breaking it down, and things of that sort, then I think there's a real benefit here.

CHAIRMAN PELLEGRINO: And that will have to be the last comment, because we are in violation of contract for all the time we go over 5:30.

PROF. GEORGE: At least it's not a covenant.

CHAIRMAN PELLEGRINO: Bill?

DR. HURLBUT: I just have a few reflections. I think maybe it's good to get them out, since this is the context of our larger effort. It's not a direct sequence to what was said here about the social/political dimensions.

But reading your essay and reflecting on what Leon said about the personalism of your articulation of the notion of declaration of professionalism and its personal covenant and how they might connect with the broader social engagement and social responsibility, it strikes me that there are a few things worth saying. These may sound a little abstract, but I think there are tangible ways we could articulate them.

One thing that - and I don't know quite how to even say this. But I feel as if, as a physician trained in what I consider to be a very privileged kind of encounter with humanity, seeing people on the gurney

is like nothing else. I think because of certain social factors, we've become overly self conscious and somewhat dishonestly humble about what we - who we aren't.

And I think there's a sense in which we might be able to say something about what we are, or at least what we ought to be, given the privileged encounter that we have in medicine. And so in an idealized way I'd like to put out just a few things about that, quickly, and we can come back to them some other session.

It seems to me that as a physician, we have a very unique appreciation of the psychophysical unity of the human person, that we understand that what a person is to a certain extent a product of forces that they didn't choose, that they inherited genetically or circumstantially. And that's a very strong root of compassion that I think only a person trained in biology can really plumb.

Second, I think we see the fragile balance that the psychophysical unity means, that there is a danger of its disruption, and therefore, we have to be very careful what we use the new powers, especially as we gain powers through biomedical technology, what we as a profession use our powers for. That there is a connection between our biochemistry and our personal and spiritual existence that we should not disrupt.

Third, I think that we have a privileged encounter with what you articulated, the frailty and finitude of life, and that therefore, a sense that life isn't always about what you might think it's about if you're just watching television. That life is a very serious journey, and that sooner or later, whether we want to face it or not, we will see it from the horizontal as a serious matter.

And this gives us a particular relationship with the reality of suffering, and a role that I'm very aware of. My wife is a pediatrician, and she comes home some days and is very drained, and needs a little kind of lifting up, and she's very strong. But it keeps reminding me of what I know from my own experience as a physician, that we do more than just diagnose and treat; we also absorb.

We absorb an awful lot of fear, we absorb frustration, disappointment in people's lives, and even anger, and that this is an intrinsically self - not just self-effacing, but self-draining, in a way. Something - it takes a lot out of you to encounter this. And yet it's a very great giving. There's an implicit kind of sacrificial relationship that's involved in this profession.

And finally, I think that - I don't know how to even articulate this. But it's very plain to me that medicine as a profession is a profession because it has a limited prerogative. It isn't about everything. We are not going to properly ever relate to our larger social engagement properly, in my opinion, as engineers, nor are we ever going to really be a substitute for priests and their equivalent in various languages.

And finally, it struck me as one of our speakers was speaking about the White Coat Ceremony - it struck me that - you used the word "sacred," I believe, earlier today. It struck me that it's very interesting this is a white coat; it's not plaid, it's not striped, it's not paisley. There's something about the white coat. There's a kind of a purity - is that the right word? There's a kind of trueness in it, a nobility, a dedication, and a mercy to go along with being a physician.

There is an effacement of self-interest, as you said. But you made an interesting statement in your paper. You said, "This is not to demand absolute or heroic activism more than is expected of nonprofessionals." And yet, there is a special role here, and that strikes me as modeling a dimension of reality that isn't plain to the average person.

So whether we're more dedicated and more sacrificial, no, that's not the point. The point is that ours is a very special role, that we model in this arena where these kinds of issues are so vivid and evident, deeply personal, deeply vulnerable.

And this unequal relationship does give us a special, a privileged understanding that we don't need to apologize for, but that we need to live up to. It makes failure more troubling, obviously, when it's unethically conducted, but it also makes a competent and compassionate profession all the more powerful.

CHAIRMAN PELLEGRINO: Thank you very much. Well, thank you all for your comments, and I appreciate it very, very much, and allowing me those few moments, those few quick remarks. Thank you.

(Whereupon, the proceedings in the foregoing matter went off the record at 5:48 p.m. to resume the following day, September 7, 2007 at 8:30 a.m.)





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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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FLOYD E. BLOOM, M.D.

COUNCIL MEMBER



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

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

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

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

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

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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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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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LEON R. KASS, M.D., PH.D

COUNCIL MEMBER



Leon R. Kass, M.D., Ph.D., is the Addie Clark Harding Professor in the Committee on Social Thought and the College at the University of Chicago and Hertog Fellow in Social Thought at the American Enterprise Institute. He was chairman of the President's Council on Bioethics from 2001 to 2005.

A native of Chicago, Dr. Kass was educated at the University of Chicago where he earned his B.S. and M.D. degrees (1958; 1962) and at Harvard where he took a Ph.D. in biochemistry (1967). Afterwards, he did research in molecular biology at the National Institutes of Health, while serving in the United States Public Health Service.

Shifting directions from doing science to thinking about its human meaning, he has been engaged for more than 30 years with ethical and philosophical issues raised by biomedical advance, and, more recently, with broader moral and cultural issues. From 1970-72, Dr. Kass served as Executive Secretary of the Committee on the Life Sciences and Social Policy of the National Research Council/National Academy of Sciences, whose report, *Assessing Biomedical Technologies*, provided one of the first overviews of the emerging moral and social questions posed by biomedical advance.

He taught at St. John's College, Annapolis, MD, and served as Joseph P. Kennedy, Sr., Research Professor in Bioethics at the Kennedy Institute of Ethics at Georgetown University, before returning in 1976 to the University of Chicago, where he has been an award-winning teacher deeply involved in undergraduate education and committed to the study of classic texts.

His numerous articles and books include: *Toward a More Natural Science: Biology and Human Affairs* (1984); *The Hungry Soul: Eating and the Perfecting of Our Nature* (1994); *The Ethics of Human Cloning* (1998, with James Q. Wilson); *Wing to Wing, Oar to Oar: Readings on Courting and Marrying* (2000, with Amy A. Kass); *Life, Liberty, and the Defense of Dignity: The Challenge for Bioethics* (2002); and *The Beginning of Wisdom: Reading Genesis* (2003).

His widely reprinted essays in biomedical ethics have dealt with issues raised by in vitro fertilization, cloning, genetic screening and genetic technology, organ transplantation, aging research, euthanasia and assisted suicide, and the moral nature of the medical profession.

Dr. Kass is married to Amy Apfel Kass, Senior Lecturer in the Humanities at the University of Chicago and Senior Fellow at the Hudson Institute. The Kasses have two married daughters and four young granddaughters.

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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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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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CARL E. SCHNEIDER, J.D.

COUNCIL MEMBER



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

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

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

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