In his classic work, "Religion and the Rise of Capitalism," R. H. Tawney warned that "Economic ambitions are good servants but bad masters."(1) My theme for this year's Abner Calhoun Lecture is an extended footnote to Tawney's assertion as it applies to a dangerous tendency I perceive in today's debates and legislative proposals about medical and health care.

I refer to the transformation of the valid economic necessity to contain costs into an ideology - a self-justifying principle that threatens to assume quasi-moral stature. One consequence is the self-righteous pursuit of economic goals that may obscure our obligations to the sick. Another is the commercialization of the healing relationship by the growing pressure to use competition as a cost control measure.

Both consequences tend to subvert the traditional moral obligations of physicians to individual patients. After all, the fundamental promise in every medical encounter is the good of a particular patient - not society,
the family, the physician or economics. The micro-ethics of the care of individual persons can suffer badly if we turn too assiduously to the macro-ethics of social good.

Before elevating economic considerations to moral stature, then, we must reflect on their potential conflict with the premises of medical morality. Without denying the terrible reality of rising medical care costs, we must seek morally defensible solutions that satisfy the legitimate expectations of those who are sick when they consult physicians or other health workers.

Let me say as forcefully as I can at the very outset that I am acutely aware of the crushing reality of rising costs, of the competition between expenditures for health and other human goods and services, and on the deleterious consequences of an overinfatuation with medical solutions to all of life's problems. Resources are limited; they are often under- and over-utilized in medical care and optimizing their use is rational and necessary. Granting the full importance of these economic exigencies, we must not let them obscure the preeminence of moral considerations in the care of the sick. This must be so even as we enter the new decade of the 80's with their dark forebodings of economic disaster for our nation and the world.

My theses will become clear, I believe, if we proceed as follows:
first reminding ourselves of the central moral obligations in the medical encounter, then examining the nature of some current and economically inspired models of care and their points of conflict with medical morality. And finally, suggesting a stance for physicians that reconciles economic sensitivity with medical ethics.

I. The Central Canons of Medical Morality

I have recently suggested in some detail the need for the grounding of medical morality in a philosophy of the healing relationship and I will, therefore, touch briefly on only one crucial point here. We can most expeditiously uncover the point most relevant to a potential clash between medical ethics and economic ideologies by reflecting on one question - what expectations may a patient legitimately hold when he enters a healing relationship with his physician? What does the physician promise implicitly and uniquely to each person who seeks assistance?

At a minimum, the physician simply by presenting himself as such to a patient and agreeing to care for him promises that all his special skill and competence will be put at the service of the patient. The prime focus of all the physician's activity is the good of the person who presents himself here and now - not some distant patient who may be more worthy, not the good of society, the family and certainly not the good of the physician or the institution he may serve.

The healing relationship is based in a relationship of trust, in a
promise of assistance and in a covenant, arising out of the vulnerability of the sick person, the capabilities of the physician and his act of profession. (3) The patient expects the physician to become his agent, to manage his recovery in his (the patient's) best interests and to take every reasonable measure to make him well again or to ameliorate his symptoms. The essential thing is the patient's expectation that whatever is advised or done will be in his behalf and in the interest of his healing.

This is the moral center of medicine, the moment of clinical truth, the point on which the physician's science and art converge. Deciding what is right and good for a particular person and acting as his agent in carrying out that decision is what gives medicine its special character among human enterprises.

In democratic societies the patient does not expect his physician to be the agent of economic policy or to introduce social cost/benefit considerations in making his clinical decision. The physician, to be sure, operates within broadly defined public policies and is never totally independent of them. But he also has a responsibility to resist such policies when they are detrimental to his first trust - the good of his patient. The physician's prime obligation is as his patient's advocate unless the patient's welfare immediately and urgently threatens the welfare of others (the patient with a dangerous contagious disease or the dangerously psychotic). A distant threat to the economic well-being of society cannot compete morally with an immediate and urgent need of the patient.
None of this implies that the physician should be socially irresponsible, that he must satisfy the patient's every whim, or that he should not participate in public policy decisions about the optimal use of resources, their allocation, and efficient application. What is implied is that it would be a violation of the obligation of the covenant between physician and patient not to place this patient's concerns and needs above economic, social and political considerations. The physician-patient relationship takes place in a societal frame to be sure, and neither party can totally evade social responsibility. But when micro- and macro-ethics are in conflict, the interests of the patient can be set aside only in the most exceptional circumstances.

II. Use and Abuse of Economically Inspired Models of Care

The interpretation of medical morality just outlined must come increasingly into conflict with current and future models of care designed primarily to contain costs. These conflicts and the "tragic choices" they entail must be recognized and dealt with consciously. They will not disappear and to ignore them can be fatal to both our moral and economic sensibilities.

Some of the conflict arises from an abuse and misapprehension of what can be expected from economics and some derives from specific measures and attitudes inherent in the currently debated and often contradictory models of cost containment. Let us look briefly at these two sources of conflict between medical morality and economic policy.
A fundamental aim of economics is to seek an optimal allocation of scarce resources to meet human needs. Economics is competent to deal with the analysis of means of allocation and their consequences, with questions of efficiency, productivity, cost, price, with benefits at the margin and even to assign approximate dollar values to illness produced, loss of life, function, or social contribution. What economics cannot do is to determine what is right and good in the moral sense for individuals or society because moral considerations by their very nature take precedence over all other considerations.

Economics is not competent within its own methodology to define the goals and values of society or to override considerations of personal morality. Its special function is to analyze the economic consequences of proposed policies as objectively as possible so that options can be chosen rationally. It is interesting that in its recent intellectual history, economics itself recognizes this limitation. As Daniel Fox shows, the early economists were far more prescriptive in their recommendations than their present-day colleagues.\(^{(4,5)}\) Unfortunately, those who make public policy often expect more from economics than its practitioners would themselves claim.

It may happen that what is good in an economic sense is also morally good but the connection is not a necessary one. When economic good conflicts with other definitions of the good some other discipline is required to establish a priority - either moral philosophy, theology, or both depending
upon our belief systems. Economics cannot substitute for the moral sciences though they need its analyses to ground their deliberations. In the end, health care economics must meet the tests of morality like every other human endeavor.

Looked at from the standpoint of good economics, the health care market abounds in reasons for escalating costs: it is provider dominated, demand is uncontrollable, maldistribution is inevitable; demand rises with rising affluence; the incremental value of investments in new technology may be marginal or negative; increasing the input of resources does not necessarily mean more health for the nation.

Equally familiar is the range of economic measures proposed to deal with the factors that contribute to rising costs: price control, expenditure ceilings, rationing of expensive or unnecessary services, limiting resource input, centralization and sharing of facilities and equipment, reducing demand through disincentives, encouraging competition, limiting care for those with little prospect of recovery of socially useful lives.

Varying combinations of these factors are incorporated in most of the recently proposed models for control of medical care expenditures. They were summarized in a recent conference on the ethics of cost containment held in 1978. A few examples from this conference will illustrate the kinds of moral choices and conflicts different economic philosophies and assumptions can produce.
First is the free-market approach which is energized by the attractions of competition among providers as a cost lowering device. Health on this view is considered no different from the purchase of any other commodity whether it is beer, pantyhose or bread.\textsuperscript{(7,8)} Physicians have property rights over their skills; they may sell them to whom they choose and under conditions they set. People can buy as much as or as little care as they choose. They can shop among HMO's, insurance plans, hospitals and clinics for the best buy. Some concession is made to the poor who would be covered by some minimum level voucher system but on the whole the consumer buys and gets what he can afford.

In direct opposition are the regulated government-insured consumer controlled models providing extensive coverage and favored by many unions.\textsuperscript{(9)} These models are predicated on the unworkability of free market systems. They emphasize rigorous national planning and regulation of the distribution of services, personnel and facilities so that equity of access and availability and comprehensive services will be assured.

Another approach, also based on the unworkability of free market systems, is the public utility model.\textsuperscript{(10)} Proponents of this view hold that health care is a civil right and that government should assure equitable distribution as it does with power or telephone service by franchising and regulating delivery. In this way the burdens of cost containment will not be borne primarily by the poor. Emphasis is on primary and preventive services for large numbers rather than expensive technology for the few.
Each of these opposing models uses a different set of economic assumptions to achieve the common aim of cost containment and each raises different challenges to medical morality.

In the free market models, the prime principles are the freedom of the provider and competition as an alternative to public regulation. These measures are intended to increase the efficiency of providers and motivate them to lower prices. Consumers would be sensitized to costs through incentives to choose cost effective options. Sharing by consumers in the costs of over-utilization or expensive procedures is expected to reduce demand for care.

Competitive models place efficiency and cost reduction above equity of access and availability, threaten the previously accepted principle of a single standard of care for rich and poor, and militate against comprehensive and preventive care in favor of minimum affordable care. But how free is the consumer when he is ill and needs more care than he can afford? When the major purchasers of care - government and industry - contract with the lowest bidders, the consumer's choices are limited even under the best circumstances. How do these limitations affect the physician's obligation to seek the best interest of his patient? Is health care really in the same category of commercial exchanges as beer and bread? What do we say about the kind of society we want, and what we think most important in these competitive models?

The competitive models aim to discourage the use of hospitals, extensive
diagnostic work-ups, expensive technologies and specialist referrals. Disincentives are needed to avoid abuses of these resources. But how far can we go in this direction without compromising adequate, to say nothing of optimal care? How much disability and suffering will disincentives produce among those who need but cannot afford these "extras?" When does an "extra" become an essential?

The government insured models, whether consumer controlled or operated as public utilities pose moral problems, too. They aim for comprehensive coverage and removal of the financial obstacles to equity in accessibility and availability of care. They are in this way more morally responsible than the competitive models. But these models must also practice cost containment and they do so by bureaucratic means - strict planning and control of distribution of facilities and services and regulation of providers - their supply, fees, location, specialty and number trained.

These models raise questions of medical morality as serious as those with the competitive models. The benefits chosen, the groups covered or excluded, the choice of volume, primary and preventive care versus intensive acute care, can run counter to the need of individual patients. Value choices are made by an institutional provider rather than the individual consumer. These choices may not represent what patients need when they are ill as opposed to what they want when they are well.

Institutional and corporate providers - government, HMO's, unions -
must shop for contracts with the most economical providers just as individuals do in the competitive models. Efficiency, productivity, standardization become important considerations with constraints on the physician's discretionary privileges in dealing with his patients. The less affluent may be a little better protected than in the competitive models but transferring value decisions to a corporate entity is no guarantee of just or moral choices.

There are some specific measures common to almost all the models proposed to curtail costs. Let us look quickly at a few of them to see the moral dilemmas they generate.

One beguilingly popular measure at the moment is the limiting of the use and development of expensive new technologies. There is no doubt of their contribution to rising costs but the utmost care must be exercised in setting restrictions. This is evident in the recent history of the CAT scanner. Legislators, planners, economists quickly seized upon this instrument as the prototype of technological overkill. They called for cost-benefit analyses, rationing, centralization and sharing of available instruments. It became rapidly clear, however, that the CAT scanner offers distinctive advantages in neurological diagnosis.\(^{(11,12)}\) It is a non-invasive, complication-free ambulatory technique as good as or superior to existing methods, especially useful in reducing craniotomies for head trauma and replacing such disagreeable procedures as pneumoencephal philography in the diagnosis of tumors.

The question now is whether we can morally justify denying patients
with suspected brain tumor, cerebral hemorrhage or sub-dural hematoma the benefits of this device. Charges are still high; savings are difficult to demonstrate. What is the meaning of cost effectiveness in such instances? What is the human value to a particular patient of a speedy diagnosis by non-invasive means? What is the "added value" of assuaging anxiety when brain tumor is suspected?

Is centralization and sharing defensible with a procedure of such evident utility in so widely distributed a problem as head trauma? Head injury does not distribute itself according to hospital size or availability of instrumentation. Moving patients with head trauma adds risks; decisions about craniotomy cannot be safely postponed.

All new technology does not evolve in this clear way, of course. Many new techniques are marginally effective or not at all effective. But each new advance may pose similar moral questions. We need not be victims of the technological imperative to question the advisability of restricting the search for new techniques. How do we calculate the benefits of a new breakthrough? Even the technological failure paves the way for more successful techniques. It is true that overall morbidity and mortality are as dependent upon sanitation, jobs and housing as on technological breakthrough. But how can we know the trade-off in advance? Small pox immunization has eradicated that disease long before we could have hoped to do so by sanitary measures, even if that were possible.
Another conflict between economics and medical morality arises in the current move to reallocate funds from "curative" to "preventive" medicine. Here the conflict is less immediate than in the case of an effective new technology. There is no question that the cumulative economic impact (disability, loss of productive days, cost of care) consequent on poor personal health habits is enormous. If we could eliminate smoking, alcohol, poor driving, poor diets, sedentary living, and dangerous working environments, billions of dollars would be available for reallocation for other needed human services. Why not deviate limited funds from the care of those with incurable disorders in which there is only a dubious marginal benefit in treatment or from the severely mentally ill whose future even after recovery may be short lived?

The question is economically reasonable but again the complexity of human existence intrudes. What do we do when the funds allocated for "curative" medicine are exhausted? Healthy people may agree to a policy of prevention. When they become ill and are in immediate need, they are far less likely to think about the economic impact of care versus cure and prevention. What physician or hospital can turn away the sick in favor of the future social benefits of those who will not get sick? Where is the line between effective and palliative treatments, or between "needed" and unwarranted care drawn? Is there a moral justification for not treating those who persist in smoking or drinking? What advanced society, let alone what health professional, could justify this kind of statistical morality?
Often overlooked by the enthusiasts for prevention is the fact that truly effective prevention might actually increase the total medical care costs. The number of aged people increase; they would live long enough to develop incurable chronic disorders. Prevention presumably would afford more healthy years in mid-life but also more years of ill-health toward the end of life. This would not be an argument against prevention but it shows again how economic end points must be interpreted in the light of other than economic values.

Again, the traditional canons and expectations of medical morality demand that we help those who are ill now and present themselves for care now. No matter what large scale policy decision may have been made, the physician cannot reject the person in need and remain faithful to the obligations he/she incurs in agreeing to treat. It is not likely that given the choice, society would wish to change its expectations of physicians os drastically as to make them instruments of economic policy rather than advocates for the individual patient.

The same considerations obtain for a variety of other measures aimed at containment. Let us suppose we place a "cap" on all hospital construction as has been proposed, though recently rejected by the Congress. On the surface, this seems very reasonable. Limiting the number of new beds should encourage better use of existing beds and avoid unjustified utilization and duplication of facilities.
But again we must examine the medical-moral implications. When do existing beds become so obsolete that they are no longer suitable for caring for the sick? What is the proper use of a hospital bed? Often the crucial factor in recovery is getting the patient out of the home or work environment. A medical condition like uncomplicated peptic ulcer might be as effectively treated on an ambulatory basis but it might take longer and result in less understanding of the psycho-social factors in causation and less complete cure than if the patient could break the cycle of stress more completely in the hospital.

What dollar value do we place on those "extra" days in the hospital for a young mother recovering from pneumonia or surgery? Or the days "consumed" by the elderly man medically ready for discharge but as yet unable to cope with daily life without completion of family arrangements? Are our resources so constrained that standardized rules about how many days it takes to treat a disease should take precedence over the number of days it takes to treat a patient. Nothing more completely violates the uniqueness of illness in individual patients than standardized and formularized care. Granting the existence of abuses of hospital bed use, the problem now seems to be to rescue the patient from overzealous application of formulae that carry the sanction of peer review.

What do we do about mounting pressures to deny expensive treatments to patients with limited prospects for survival or limited chance for eventual recovery of a "productive" or "socially meaningful" life? It has been shown that 70% of the most critically ill patients, despite maximal therapeutic
intervention, do not survive beyond 12 months. Yet these same patients consume resources - money, people, equipment, time and energy in enormous amounts. (14) We cannot deny these expenditures to those patients when they present themselves even though the economics of resources allocation would suggest such a course. How resolve the conflict between high costs and low social benefits for the care of the retarded, the aged, the patient in intensive care, the patient needing to be dialyzed and the dubious social benefits of such treatment? Is the physician free to apply economic considerations when his covenant is with his patient, not society? Some would have physicians act as economic monitors. Others would have them place social benefit before individual needs and desires.

Every measure aimed at rationing scarce resources entails ethical dilemmas of this kind. The tension between micro-and macro-ethics promises to become more troublesome as costs mount further and resources become more obviously scarce. "Cost containment" and "everything for every patient" are opposing ideologies, equally to be avoided. Neither is morally defensible when applied as an absolute. What is increasingly demanded is some way to balance these conflicting obligations, each of which binds the physician to varying degrees. Let us turn to some of the ways in which an equilibration can be rationally and explicitly achieved.

III. Equilibration of Moral and Economic Obligations

There is much however that physicians can do without violating their fiduciary responsibilities to their own patient. Without looking for a neat
formula to resolve every conflict, let us look at some of the simpler and obvious measures.

To begin with, the primary obligation of the physician to his patient does not excuse him totally from social and economic concerns. We have already noted those exceptions when the patient's "good" might be a threat to public safety. Yet the physician must not take advantage of the vulnerability of the sick patient to advance his own, or even his nation's, social or economic philosophy. The dangers in ignoring this principle are too well attested in recent history and need no recounting here. The physician is nonetheless obliged as a citizen and as a member of a profession with a corporate responsibility to society, to take both economic and social concerns very seriously.

As citizens with special knowledge, physicians are obliged to take active part in decisions that determine health care policies and expenditures. They have the obligation to define alternatives, to explicate the moral dilemmas of a policy, and offer those modifications which will prevent a policy from overriding human concerns. To do that, they must first provide reliable data on efficacy, efficiency of medical procedures. They alone can provide the technical input essential to sound economic decisions.

This obligation will become particularly pertinent if, as some economists advise, we move toward cost-effectiveness analyses that take into account quality of life in establishing priorities. (15)
When they participate in public decision, physicians cannot assume they know what is "good" for all patients or for society. As physicians they have a considerable prerogative in technical matters, but no special prerogative in making value decisions. Ultimately the decision to follow a particular economic policy must turn on question of value: what we think the "good" life may be, what is "worthwhile" and what not for individuals and society. On such questions the physician is free to propound his personal values but he is not automatically an expert on values. Failure to make this last distinction often damages a physician's effectiveness in policy-making bodies and puts his credibility in question.

Whatever may be his personal values, the physician has a choice like any other citizen to conform or oppose a public policy. But in dealing with the individual patient his personal economic preferences or social philosophy must take a second place. If they are so important to him that he must express them through his treatments, then he must make that fact known before hand. In that way the patient can exercise the option to reject him in favor of another physician. Under no circumstances can the physician use economic constraints to "punish" patients whose values or lifestyle he abhors. Too often the physician's hostility to the alcoholic, the homosexual or the sociopath is justified by cost/benefit criteria.

These caveats notwithstanding, the physician cannot assume the attitude that "everything possible" must be done for everyone. While his estimate may not be entirely accurate there is an important truth in Eli Ginzberg's
assertion that each physician adds some $350,000 to the cost of health care annually.(16) The physician is, and must remain, at the center of the clinical decisions that determine those costs. He has therefore an unavoidable obligation to his patient and to society to contain that segment of costs over which he has direct supervision.

It is perhaps preferable to speak of cost consciousness rather than cost containment. The former attitude imposes a responsibility but does not make costs the prime consideration. Cost consciousness can be consistent with both good economics and good medicine since it is a more flexible and more prudent stance. It errs on the side of the vulnerable person - the one who is in need and is therefore consistent with the helping and healing role of the physician. Some of the measures that could fit the rubric of cost consciousness responsibly are as follows:

The first is to cultivate true diagnostic elegance, in the scientific sense of that term, that is to order only those tests which answer a specific question and which lead to some practical decision. Much more critical attention to how much evidence is sufficient for a patient's diagnosis, or better, for taking a clinical action is needed. "Shotgun" and "roulette" work-ups to cover all bases are expensive, non-conclusive, and even dangerous. Clinicians need to know when a test makes only a marginal contribution, when diagnostic certitude is possible and when it is an illusion. This is one of the major deficiencies in medical education today.

Physicians must understand something, too, of their own diagnostic and
and therapeutic "style." (17) The compulsive diagnostician keeps testing beyond the law of diminishing returns; the therapeutic enthusiast keeps trying medications beyond the limits of reason and safety; the action-oriented physician likes to "do things;" the meditators prefer to do nothing "judiciously." Each in his own way, or in specific cases, may produce excessive costs, which on critical examination are indefensible clinically as well as economically. Too many tests and procedures, too many drugs, too many consultations; too many x-rays, are the mark of disorderly clinical thinking as well as cost insensitivity.

Even more fundamental is a mastery of the basic skills of history-taking and physical diagnosis. As a consultant for many years, it is my experience that the most costly and dangerous errors in diagnosis result from failure in these basics and not in failure to order enough tests. Unfortunately, lawyers and courts are ignorant of this fact. Much of the "excess" use of procedures, tests, and x-rays constitutes defensive action against a litigation-happy society. Judging the adequacy of a patient's work-up by standardized criteria when the criteria themselves have not been rigorously justified is poor logic and poor law and poor care.

The cost conscious clinician will be severely critical of his own use of the hospital, of consultants and of unreasonable demands of his patients for the use of both. The hospital is not to be used to alleviate minor inconveniences in the lives of patients or physician. Surgeons with unfavorable morbidity statistics or over-eager scalpels must be identified
and avoided. Enough has been written about "unnecessary surgery" to indicate how abhorrent it is to good medicine as well as good economics. The same applies to the "test-happy" internist and the "procedure-happy" subspecialists.

The physician has a moral obligation to educate his patient to less costly methods of care, especially when, as is usually the case, they are more consistent with good clinical practices. To be sensitive to the patient's needs does not require being submissive to his every whim. Ambulatory care is often preferable to hospital care; penicillin for a viral infection, tonsillectomy or hysterectomy on demand and even the "latest" drug are invitations to unnecessary expense and serious side effects as well.

Even some of the measures now accepted by the profession in the interests of cost containment and quality-control need scrutiny. Peer reviews of hospital utilization and PSRO activities can themselves become self-justifying. Peer pressure accompanies peer review. Simple because there is "agreement" on some standardized stay for an illness does not give moral justification for refusing to pay for, or to hospitalize the patient whose needs are not "standard." One unfortunate response to regulation is to "give up the struggle" for optimization of care.

More critical studies are needed of the cost benefit ratios in established patterns of care. For example, a recent study comparing ambulatory care by internists and family practitioners showed that the former spent more time and used more tests than the latter. (18) Neither spent much time
in therapy for emotional problems. The paper did not say whether quality of care was different in the two groups but it raised very important questions about the relationships between quality and cost benefit. I have raised similar questions here and would emphasize their moral implications as well.

To practice cost sensitivity then requires first of all that the physician be expert in the basic tools of his own craft. Properly used, these tools will make him discriminating enough to use only those means which are most effective in meeting the patient's needs and no others. He must, in short, practice an economy of means in his daily work. This is the precise point at which the clinician can best equilibrate medical morality and medical economics so that the two become synonymous and not competing obligations.

I cannot in this regard ignore another potential conflict, that between the patient's good and economics of the physician himself. Some physicians have commercialized their relationships with patients by an excessive concern with fees and methods of payment, by refusal to see medicare and medicaid patients, or by abusing and even defrauding third-party payers. Each physician must rigorously examine himself to answer truthfully whether he is not subtly falling victim to the "doctor's dilemma" that Bernard Shaw so scathingly portrayed in his play of that name. Judge Barnes of the FTC has recently ruled that medicine is a commercial enterprise to be judged as business. He sees professional ethics as a self-protective device. How much consolation do physicians give his view when they overemphasize economic autonomy, ignore problems of distribution of care, over-utilize diagnostic and therapeutic procedures and make medicine a business enterprise?
Generalizations are dangerous here and I have no wish to fuel the angry and sweeping allegations of the more rabid physician-baiters who suspect all of us of fiscal foul play or exploitation of the sick. However, personal economic morality must accompany professional morality. The two are always mutually re-enforcing in the good physician.

In this respect, there is a serious misconstrual among physicians and medical educators about what constitutes "medical economics." All too often it is identified with the good business practices attendant on running an efficient office. Physicians do need better education in economics but the emphasis must be on its uses and limitation, on how to analyze costs, productivity, resource allocation and the like. Particularly important is a better knowledge of how to analyze marginal benefits against marginal costs for given procedures.

The growing concern about fees is underscored by a recent study of the D.C. Blue Shield fee structures. The cost escalating effects of the reasonable charge principle are underscored, as are the effects of the dominant influences of procedure oriented specialists. While such studies are as yet limited, they do point to the need for a deeper concern by the whole profession for the coming clash between the freedom to set fees and the rising cost of medical services. The profession has an opportunity I hope it will take, to examine itself before regulatory measures are proposed on what may be limited evidence.
But even this will not be enough. There must also be equilibration on the broader scale of social and public policy. Even the cost-sensitive clinician must function under policies and in institutions which can re-enforce or frustrate his efforts in the care of individual patients. Certain fundamental questions upon which policies ultimately depend must be faced much more explicitly than they have been up to now.

For example, some economists and physicians are fond of telling us that the American people do not place health very high on their list of priorities. This view is based on surveys mostly among health people. The priorities of those who are ill can be drastically different - as any clinician will attest who has attended even the most ardent cost-containing economist or health planner. We do need to know more accurately where the American people place medical care, to what extent they are willing to compromise their customary expectations of physicians and hospitals that "everything possible" will be done in their interest.

The possible compromises of this concept contained in many of the decisions now facing us have not been made clear enough to enable the public to make choices. Instead, planners and legislators respond frenetically to one crisis after another - cost escalation, variable quality of care, medicare and medicaid abuses, excessive demand for new technology, needless prolongation of life in the incurable, to mention a few. Piecemeal legislation is promoted with catchy phraseology to answer each crisis, but one solution is rarely related to the others, even more rarely are the compromises of one piece of legislation imposed on other needs and services. We hear
constantly of limited resources but infrequently what a shift in priorities means for those services we already count upon.

The public debate on resource allocation, health policy and legislation must be conducted in a more productive way. Alternatives must be more clearly delineated. For example, many planners speak of limiting health expenditures to ten percent of the Gross National Product. What is the justification for this figure? Everyone speaks glibly of the "American People" and what they will, or will not, tolerate, or what they "want" besides health care. Granting they receive their "money's worth" and granting it is efficiently and honestly provided, the figure may be higher or lower.

Nor do we really know what people want medicine for. Some argue that medicine should confine itself to "high" technology and only effective therapeutic measures. Others take the contrary view that medicine is really the instrument to total health and happiness. Still others emphasize the helping and caring functions as of equal value with the specifically curative. Which of these alternatives we choose will profoundly alter our expenditures, the kinds and number of health professionals we educate, the types of institutions we build and the minimal benefits we will provide under national health insurance, more so than any adjustments and fine tuning we may make in efficiency, increased productivity, fee regulations, or expenditure ceilings within the system.
Ultimately our health economic policies must reflect what it is we expect in the way of health and medical care in an advanced democratic society. Is primary care a human need so basic that it is an obligation of a civilized society? Does such an obligation apply to other forms of care as well? Is it possible to be a free human and to pursue other human ends if one is ill or in distress? Is health, with security, food, housing, and civic liberty among the first principles of civilized life?

These are questions of value, of what we as a society consider to be the things for which we will sacrifice. Would this sacrifice include providing the most humane care even for those whose social utility is marginal or questionable? An economically inspired morality would answer that question one way, a morality inspired by care and solicitude for others would give a different answer. How much of our amusements and diversions - the tremendous expenditures, the almost universally accepted forms of chemical coping, alcohol, coffee, tobacco - would we sacrifice for the security of medical care available and accessible to all?

No group can presume to answer these questions for the nation. Policy makers assume certain answers as the basis for their recommendations. How well do they reflect public opinion? The questions have, in my view, not been put directly, clearly, or understandably, and so I do not think we have reliable answers. I do know that in the moment of illness, when the need for care is immediate and urgent, almost every person would put all these other things aside for considerate, compassionate and competent care provided there is reasonable hope for recovery and life is not being prolonged needlessly.
These are moral questions, turning on what as a society we believe to be "good" for humans as individuals and as communities. In short, what kind of society do we want to be? Economic, as well as social and political issues are intermingled with medical-moral issues. Before we accept cost containment as the new slogan that will lead us to a well-ordered and responsive health and medical care system, we must examine these issues critically and as a society. The cynics will immediately protest that "society" cannot partake of such a critical inquiry. The only reply we can make is that if it does not, it cannot remain democratic. So important a matter as health and its impact on all other human services can be intelligently and justly disposed only if we are clear about our ends and purposes. Undeniably the physician, all other health professionals, and health care institutions have a crucial role in the equilibration of economics and medical morality. Their efforts in individual and personal medical transactions must be re-enforced by a context of policy decisions which also attempts to reach some equilibrium between the inherent tensions of the canons of morality and of economics.

This extended footnote to Tawney comes to a conclusion at this point. Economics must concern us and it must provide the analyses of means and methods best suited to achieve the ends we define for our health care system. It cannot define those ends. Human purposes and values are too closely linked to what is good and what ought to be done, to the normative questions and therefore must ultimately be decided through moral discourse.

This essay simply outlines the kinds of questions that must be con-
confronted if medical morality is not to be subverted to economic considerations.

Edmund D. Pellegrino, M.D.
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