



Why Should We Care About the Sick? Foundations for Genuine Health Care Reform

Speakers: **Dr. E. Pellegrino**—Chairman of the U.S. President’s Council on Bioethics
 Dr. P. Steinfels—Professor at Fordham and *New York Times* Religion Columnist
 Dr. D. Sulmasy—Director of the Bioethics Institute of NY Medical College

**Thursday, November 1, 2007, 6:30PM
 St. Vincent’s Hospital Cronin Auditorium
 170 West 12th Street, New York**

*transcript not reviewed by the speakers

Sulmasy: I think we’ll get started here. If people could take their seats. To welcome us and start the evening off, Mr. Henry Amoroso, the CEO of St. Vincent’s Catholic Medical Centers will welcome everyone.

Amoroso: Thank you, Dan. Now that you’re all comfortably seated, I guess this is the best time to tell you that we today received the successful bid for the new chairs for the auditorium. Dan was concerned that we would actually start work this morning, but we have, to your discomfort, postponed that to a later date.

Welcome to St. Vincent’s. This is, as so many of you know, the acute care flagship hospital of St. Vincent’s Catholic Medical Centers of New York, and my name, as Dan said, is Henry Amoroso. I’m the fortunate new CEO of St. Vincent’s, and because of that role, this is the first time that I’m privileged to help open the Annual John J. Connelly Lecture in Medical Ethics. Thank you, Dan, for this opportunity.

St. Vincent’s is pleased to co-sponsor this event with Crossroads, which, as you know, is a cultural and educational organization affiliated with the international movement Communion and Liberation. We also have support from the organization *Medicina e Persona*, Medicine and the Person.

St. Vincent’s was founded more than 150 years ago by the Sisters of Charity of New York. We have a long and an honorable tradition inculcated in us by the sisters of joining the highest standards of medical practice with the highest standards of ethical behavior. We have had a formal Clinical Department of Ethics since 1998, founded with the generous help of the John J. Connelly Foundation for Ethics and

Philosophy in Medicine, and the sisters who endow the Sisters of Charity Chair in Ethics, working in conjunction with the Bioethics Institute of New York Medical College, St. Vincent's offers extensive programs in ethics education and research, and has an extensive record of publication. Founded as it was to care for the sick poor, St. Vincent's is an appropriate venue for a discussion of ethics of health care reform. And for the Christians among us, this is an auspicious day for this topic. It is All Saints Day, celebrating the lives of Christian saints, people of faith and of honor who might be thought of as applied ethicists for the holy lives that they have led.

We are honored to have Dr. Edmund Pellegrino with us. Dr. Pellegrino is Chair of the US President's Council on Bioethics. We are honored too to have Dr. Peter Steinfels of Fordham University and *The New York Times*, joining us this evening.

Personally, I am sorry, but I have to attend a previous engagement, one that is going to draw me away—fundraising for St. Vincent's—and I will not be able to stay for the whole of what promises to be a fascinating and thought-provoking evening. But I do know that you will enjoy it, and that the field of medicine and your lives will be richer for it. Once again, on behalf of St. Vincent's Catholic Medical Centers, welcome, and please enjoy your evening.

Sulmasy: Welcome to the 16th Annual Connelly Lecture. As you know, Dr. Connelly really left an indelible mark on St. Vincent's. His clinical work really started him doing extensive and disfiguring operations to save, that were lifesaving for people with cancer. That's what actually initially began his explorations of the concept of informed consent way before the lawyers got very serious about it because he felt that a person who was going to have such an extensive operation that could be quite disfiguring would need to be involved in that decision, and he and his wife Monica, who unfortunately couldn't be with us today, then founded, as Mr. Amoroso said, the John Connelly Foundation for Ethics and Philosophy in Medicine, and they are a major support for our department. They actually have a daughter who graduated from New York Medical College as well, and I'm certainly very grateful to them. I think that St. Vincent's is very grateful to the Connelly's and we hope that we will live up to Dr. Connelly's legacy.

Crossroads Cultural Center is a co-sponsor here. They've been, as Mr. Amoroso again said, affiliated with the Catholic lay movement Communion and Liberation which was founded about 50 years by the late Msgr. Luigi Giussani. Many of you will know that about 2 years ago they helped us to co-sponsor another event here on the ethics of regenerative medicine, which I think was a terrific event, and was so successful that when no good deed goes unpunished, I'm now on the board of the Crossroads Cultural Center, and I'm really delighted that we can work together again on this.

I would also be remiss if I didn't formally express my gratitude to Medicine and the Person for their generous financial support for tonight's event. They were founded in Milan in 1999, and they're really an association of health care professionals who are like minded to many of us, that focus on the central role of the person in health care. They've recently developed a few contacts with physicians and other health care professionals in the US like me, and would like to develop deeper connections and

collaborations with those of us on this side of the Atlantic. If you want more information, there's a table outside about their work.

This is the topic for us tonight: *Why Should We Care about the Sick?: Foundations for Genuine Health Care Reform*. It's obvious, I guess, to anybody who either is sick or cares for the sick, or knows somebody who is sick, or even reads the newspaper, that our system of health care in the United States is broken. This is true for patients, it's true for practitioners, it's true from the point of view of employers as well. What to do, however, is extremely controversial. We could potentially keep the status quo for our health care system. We could maybe adjust the status quo a little bit with regulations and incentives—either incentives for patients, or for practitioners, or for employers. We could more radically privatize the health care system, go for medical savings accounts. There are even those radical people at the University of Chicago's School of Economics who would say, "End licensure for physicians. Make it a total free market, and then we'd have an efficient system which would deliver right care to people, and bring more people into the system." We could incrementally add more government share to our health care system. Right now it's estimated that at least 40% of health care is already delivered by government in some form or another. So, some people suggest just increasing the share of the government, eventually making everybody on Medicare, which is, after all, what the Canadians call their system. Or we could develop something more like the British—a national health service where the whole thing is run by the government.

So those are some of the ideas, or combinations of them, that are out there floating around, and lots of candidates are speaking about them, which is part of why it's timely to do this when we're doing it. The complexity of the question, is really, when you think about it, breathtaking. Corporations right now are spending so much money on health care benefits that they think it may be the single greatest cause of their need to have layoffs, and to outsource jobs overseas. And yet health care itself is, in fact, a huge employer. So one of the problems with closing hospitals in New York City is that a lot of people work in health care and they work in the pharmaceutical industry, and the pharmaceutical industry is among the most consistently profitable corporations in America. So do we really want to close that down?

Neither unions representing janitors nor companies manufacturing MRI machines want to see cutbacks on health care expenditures. So it's difficult on all these sides. Still, as I was sharing with Dr. Pellegrino before this, I think there's something odd about a culture like our own—we do have a reporter here from *The New York Times*—but I think there's something odd about a culture in which currently, maybe twice a month, there's a story about prevention and health care on the front page. Prevention costs money too. It doesn't just save money.

We have problems in access to health care because it's unevenly distributed for all the money we spend on it. We're up to maybe 48 million Americans who at some point during the year have no health care insurance. That's not counting the undocumented who come to hospitals like St. Vincent's on a regular basis. And physicians and nurses, of course, have the problem of being on the front lines, in the trenches with this, and we bristle at the thought that someone might be telling us what to do, what we can and can't do for our patients, and yet we know that there's waste within the system as well.

Even 20 years ago, one observer put the problem this way—actually it was Tris Engelhart—not exactly somebody I’m always a fan of, but I think he was apt in saying this, “Part of the problem we have is that in America, with respect to health care, everybody wants everything; no one wants to pay for anything; and no one wants to say ‘no’ to anybody.” This is obviously an unsustainable set of premises.

What do we do? We could leave it to the politicians and the policy wonks. However, I think what motivated us to have this session tonight is that in the end we don’t believe that this problem of health care can be reduced to simply a technical problem, or simply an economic problem. The fascination with health care that all of us have, and one of the reasons I think it’s so popular on television and the like is that it’s so deeply personal in the end. Robert Sokolowski at Catholic University, a philosopher, once put it this way, “When I go to the accountant, my taxes are the issue. When I go to the butcher, my stomach is the issue. But when I go to see the doctor, I am the issue.”

So fundamentally we think this is an ethical question about how we should structure the delivery of health care. I think Dr. Pellegrino is going to say something about this later. In Aristotle’s writing, the politics follows the ethics, but the ethics is fundamental to how we think about our political lives together, and a lot of people don’t even realize what Adam Smith’s day job was. Adam Smith held the chair of moral philosophy at the University of Glasgow. He was a moral philosopher. And so the questions about how we even structure a health care system or an economic system of any sort is fundamentally moral.

So the questions we want to ask, and we think are raised by these questions, are more questions like who we are as a society, who the sick and dying might be in relation to the healthy, how do we confront our finitude? What do we think is the value of life or health? And what’s the value of the relationship between a health care professional and a patient?

We lack, don’t we, when we listen to debates, and if any of you listened last night to yet another one, I think what we lack is a clear lens by which to examine these proposals for health care. And we’re not here tonight to debate Hilary versus Obama versus Rudy versus Romney’s health care plans. They probably won’t, before an election, give us enough detail to really do that seriously anyway. We’re going to actually try to think about the moral criteria for answering those questions.

So our program is going to proceed as follows: First I have to tell you, even though it’s in the program, that Marilyn Wiendler, who was supposed to give us a brief snapshot from the nurses’ perspective, is now happily a grandmother. Jeffrey was born on Saturday, and so she is with her daughter and grandson and can’t be with us tonight. So we’re going to go directly to Dr. Pellegrino’s talk to help us answer those questions, giving us some guiding principles for moral examination of health care proposals, and after that we’re going to ask Prof. Steinfels to come up to the podium and begin the questioning sort of in an interview style with Dr. Pellegrino for about 20 minutes, and then we’ll open it up to all the rest of you for what we hope will be very ample time for a dialogue.

So with that as a beginning, let me introduce our featured speaker tonight, Dr. Edmund Pellegrino. He, as I think you all know, is the current chair of the US President’s Council on Bioethics. He’s a professor

emeritus at Georgetown University. He has a long and distinguished career, and I'll just give you some of the highlights of Dr. Pellegrino's career. He's a New Yorker, which is very important to start with, and went to St. John's as an undergrad. For those of you who are also from the city, he went to NYU for medical school and trained at Bellevue in the days when Bellevue was Bellevue. He became the chair of medicine at the University of Kentucky at the tender age of 35. He served as President of Yale New Haven Medical Center. He was the first dean at Stony Brook Medical Center, President of the Catholic University of America, former director of the Kennedy Institute of Ethics. Many people would like to have one of those things on their CV and consider that an accomplishment of a lifetime. It's very impressive. I also have to tell you that like one very high-end restaurant I was once taken to, not exactly great for a friar to be in one of these, but I was asked to go and I went along. It had its wine list in 2 volumes—one for red and one for white. Dr. Pellegrino's CV comes in 2 volumes basically—one for science and one for the humanities, mostly the ethics work he's done. It's an enormous corpus of work he's left us. And I'll say personally that I first started as a medical student reading Dr. Pellegrino's work and I thought at that time it would be wonderful if I could grow up in medicine to be that kind of a doctor and it was a great privilege for me to be able to meet him as a resident, to be able to study with him, to count him as my mentor, both for my doctoral dissertation and for many other things in life. And so, without further ado, I will introduce to you and ask you to welcome Dr. Edmund Pellegrino.

Pellegrino: I thought you were going to ask me a question.

Sulmasy: Dr. Pellegrino said he thought I was going to ask him a question. I thought I had buried it in there, but the question we want to ask is, to begin with, how should we, from a moral point of view, examine health care proposals?

Pellegrino: Thank you very much, Dan. First of all, it's a pleasure to give the John Connelly lecture. I had the privilege of knowing Dr. Connelly and he certainly had questions with respect to the field of bioethics, recognizing it early on as intrinsic to the future of medicine and the behavior of those of us who are physicians. With reference to Dan Sulmasy—very, very generous introduction. Let me only say that of the 18 students I have mentored for the PhD in philosophy, Dan is the number one. That's just not retribution for the wonderful introduction he gave me. Thank you very much, Dan. Also I want to point out that Dan has assigned me 30 minutes and he's very precise about that, and I know from my past experiences that should I expatiate beyond that time, it will be some body language in the first row—cut it out! So Dan, I'll keep my eye on you and we'll go briefly.

As Dan pointed out, he would like me really to open up the subject so that we can have a productive dialogue. That's what I enjoy most. Peter Steinfels will, I am sure, ask very acute questions, and I will probably have to practice the art of circumlocution and prestidigitation of words, but I'll do my best to avoid answering the very, very hard ones.

I have to also say at the very outset, since I am the chairman of the President's Council on Bioethics, I have to say all of my opinions will be my own, they do not represent the council, and as a matter of fact, the subject that's being discussed at the present time, we have not made a commitment to produce a

volume on it. And the last thing, I am greatly relieved that I do not have to comment on any of the existing proposals that are being made and will be made in exponential fashion over the next year or year and a half, during the presidential election campaigns. No prejudice against any of those, but I happen to think that when we manipulate the plans, we're still not getting at the fundamental question, and as Dan intimated in what he was saying, I think the fundamental question is a moral one, and this never appears in any of the debates. You didn't hear it some years ago when the Clintons proposed a program. You haven't heard it really seriously from anyone.

The question really is (I'm not going to solve it tonight, but I'd like you to have it in the background of your sensorium as I talk about some of the issues I think are worthy of discussion at this stage of the game) Are we a presumably good society, or one that thinks itself good? Do we believe that the sick and disabled among us have a moral claim on the rest of us for assistance? It usually plays in economic terms. We're an affluent nation and we have people without insurance. My concern is somewhat more clinically oriented since I am a physician and I am still making rounds in the wards of the hospital, and therefore do see sick people. My concern is not so much for health care—and that's going to disturb a lot of you. You're dedicated to health care. So am I, but there's an order of priorities—the most immediate and urgent problem facing us as a nation is that there are human beings who are acutely ill, chronically ill, in emergency circumstances who cannot have access to the best that we have to offer in American medicine, and many who are made poor people as a consequence of the cost of health care. And just think of it for a moment. Each and every one of you here, I suspect in this group we do not have too many who own oil wells, and if you don't, anyone of you could be struck down at any moment with a catastrophic illness. I am concerned about the sick people not receiving health care today. I hope that doesn't disappoint health care advocates, but as a clinician, I'm concerned about those who present to us.

I'm going to show a few slides just to provide a background, and make some cursory remarks so that each and every one of them—I'm not going to give you an answer, and I certainly am not going to oppose a system of my own or a new system or somebody else's system that I am presumably in favor of. Let me start with the first slide, and Dan, if I remember the high technology of this apparatus...As you can see, I'm an internist of the old-fashioned. I can't do anything except talk, and then sometimes not very productively.

Here's the issue as I see it. Justice in health care is certain to be a recurrent subject of debate in the years immediately ahead. This is obvious to all of you. All of us were required to come to grips—all of you as citizens of this country—with the question of justice and health care allocation, availability and accessibility. Underlying our response, there's going to be some answer to the question of whether health care is a right, a privilege, an obligation of a good society, or a commodity like beer and panty hose that can be left to the operation of the marketplace. What would your opinion be? I'm starting out by presenting the opinion, decision to you. It will be decided by the American people, and I think the American people's answer at the present time is insufficient. I will return to this at the very, very end. But in doing so, you will be putting forth some notion of justice, so I'll start with a few slides outlining where we are in justice, and then take it from a broader view, and bring it down to what concerns me—

not as a policy-maker, but as a physician who is still seeing patients and still seeing the deprivation of disease on human beings.

Forgive me. I'm criticized over and over again because of my concern about sick people. You may criticize me as well, and I hope you do, so that I can respond.

Now, let's move on to just a little notion about what justice is. I found the slide myself this time! It shows you that even at the advanced age of 87, you can teach an old dog some new tricks! This may sound a little bit distant and a little bit abstract to most of you, but it is not because, as I said at the opening statement, you're going to have a notion of justice because it comes down to the question we said earlier—do we owe anything to the members of our society who are ill, who are disabled, who are in need of care? Not so much now about instruction in health and so on. I'm fully aware of preventive medicine, but that comes second. Prioritization is a key issue when we're dealing with a limited resource, and that's what we are working with this evening.

Well, it's a principle, those of you who are familiar with the most famous book in bioethics, Beauchamp and Childress say it is a principle, meaning that as a foundational statement, a proposition which says that it ought to be observed and one should act in such fashion that one is just in the distribution of medical care. Its historical origins are very old and I don't think the moderns have added anything to these definitions. Plato discusses in *The Republic, Books I and II*, Aristotle, and so does Aquinas. Let's look quickly at the way they see the problem. We may want to use one or two of their perspectives as we look at the issue.

As a virtue, Plato was the first to introduce the idea as a virtue. A virtue is a disposition, a *habitus*, a habit of acting in such a fashion that the good of the act that you're acting can be achieved with some degree of perfection. It sounds abstract, again, but wait. We will be much more concrete about it.

Habitual disposition Plato saw as an internal assembling of the ordinary parts of our inner existence, so they're in correlation with each other, and it's necessary for our personal happiness. Social justice, he said, is that every member of the state fulfills a function to which he is naturally fit.

Aristotle talked about distributive justice, and the minute you talk about justice in health care, people jump to distributive justice, and I'm going to again point out that there is a limitation to this particular point of view. But he said that to each what is his due according to merit renders equals equally, and unequals unequally; that is to say, if you didn't have sufficient merit, you would get less of whatever it was, the health care or whatever the distribution would be. Aristotle then, with a great wisdom, as he always does, reflected enough, and introduced the notion of *epikia*; it's the notion of equity. Those in the law know about courts of equity which arose in the early part of English law many centuries ago. When it's a correction of law or principle where it might be defective if applied universally; this will become concrete shortly.

Aquinas picked up both parts—Plato and Aristotle—and he sought as a virtue that which makes man capable of doing just actions in accordance with choice; this applies to all of us when we get to

consideration of the question. Elsewhere, and this is crucial, Aquinas said that charity is the ordering virtue, not justice, and justice is shaped by charity. And he, in a way, when looking at distributive justice, the justice that goes with the allocation of a limited resource, which we'll be spending most of our time on, that's very much akin to the Aristotelian notion of *epikia*.

I want to establish here very quickly that the notion that a strict application of justice based on merit or any other principle, has to be modified by some notion of equity or *epikia*. It's what I call justice with the blindfold removed. We can see the person on whose benefit we are acting.

What are the varieties of justice? We're still in the preparatory realm. Retributive justice is justice which makes up for injury that may have been done in the past. We've had that, we do have that—centuries of social discrimination and so on which has still persisted and in which now has a tremendous effect on the health of a significant segment of human beings in our country. Corrective justice—try to put things back to normal. I'm not going to spend time on any of those. I want to spend time largely on commutative and distributive justice because I'm going to be talking about justice at the personal level, and I notice we have as one of our co-sponsors, Persona and Medicine.

So let's go down this pathway, and against that background, let's take now the following thesis that I want to propound: Justice in health and medical care, and predominantly in medical care, is an obligation of a good society, a moral obligation of a good society. I did not put emphasis on right or privilege. If it's a privilege, as many people argue, you can have it if you can pay for it. If it's a law, strictly speaking, instead of being just a privilege, it's a law, required by law, we don't have such a law. They do in other nations. But if you look at a good society, now going to Aristotle's notion—remember the politics and the ethics follow each other—the ethics of Aristotle had to do with what a good society owed to its individual citizens, each citizen, on a thesis that you could not have a good society with people who were not themselves good and who could not flourish. The aim of a good society with a flourishing, to the extent possible within the limitations that human life imposes, enable them to flourish within whatever limitations are placed on them. If ethics depended on the fact that if we had good people we could have a good society, we have people who are able and healthy, how could you flourish in any way if you are ill? It's as simple as that. And Aristotle has argued that we need people in our society who are able to function to the best of their ability, and our society has the obligation collectively and commonly to bring that about.

Now respect for persons arises immediately out of commutative justice rather than distributive justice, and here is where I enter the big issue as I see it. I believe that health care, medical care, and medical care is my first concern, is a moral obligation of any good society. The time is limited, and therefore I'm not going to try to define that. Peter I'm sure will ask me some questions about that, and you will too, and I'll be happy to try to defend it, but what this produces is a problem that I see emerging all the time. Bioethicists today, quite a few of them, are saying the prime motivation of the physician should not be the welfare of the individual patient. It ought to be the preservation of society's resources, so that we can distribute them. Now, there's nothing wrong with that statement except that when you are a clinician, that's a nurse, a physician, social worker, those who confront human beings in the predicament of

illness, their prime and first moral obligation has to be to the individual. Commutative justice takes precedence over distributive justice at the bedside. I want you to remember that because if we accept the notion that we have a moral obligation, it's going to be affected at the bedside, and the present leaning of many bioethicists, not all, is that we physicians should be the persons who preserve social resources and that we should be practicing distributive justice in the one-to-one relationship. Commutative justice deals with the relationship between individual human beings. Distributive justice, how do we assign and allocate the goods of the whole society. The physician, the nurse, should not ever be the agent of distribution, the agent of rationing, so I believe we will have, some day, a system which will take into account the moral obligation of a good society, but that will have to be balanced against the good of the individual patient.

The Hippocratic ethic and the Nightingale ethic for nurses, emphasizes commutative justice. What is owed to the individual person, this will go against the grain with many of you who are more socially oriented, but you must understand there will be a conflict, and rationing will have to be a part of any system, however we devise it, and that rationing must be made on an external basis, a social basis, a socially agreed basis, and not by an individual physician.

Fidelity, Voracity and Beneficence are the obligations of the active profession. When you come into my office and I say to you what I can do for you, you expect me to be competent and to use that competence in your interest, not the interest of society, not the interest of the hospital, not the interest of the HMO, not the interest of the insurer, not the interest of anybody except you. That's the covenant.

Now, how do we preserve that? First, we want to emphasize that we have our prime responsibility to the patient and not to the distribution of resources. Let's see where that takes us as we move a little more closely to the application of the notion of justice.

Distributive theories are going around all over the place. I'm not going to go into them in detail, just to say that they may come up in our discussion. But who gets what is a problem of resource allocation for the whole society. I'm shifting from the physician, the nurse, the clinician who has the resources immediately available that are needed by the sick person. The problem of resource allocation, you can apply a series of criteria, none of which I think hold up necessarily. The utilitarian which means for the greatest good for the greatest number of people. Measuring that has many theoretical problems I won't go into. The libertarian who says we have no obligation whatsoever to the sick person. The libertarian says, "You have no claim on me." And I'm arguing that we have a claim, we have a moral claim as a virtue of a good society. Communitarian, a contractual arrangement, what's better for the community as a whole. The Egalitarian who says everybody's treated equally. You will have to decide which of those approaches you're going to take, but the final determinant in my view will be a set of criteria we'll talk about as we come to the close of my remarks and keep my promise of a half hour and no more than that.

The Egalitarian theory is a radical one, strive for the greatest opportunity. This is the one you want to use for quality, even if it lowers equity or favors the disadvantaged. John Rawls, the most famous name in justice today, certainly in bioethics—equal rights, basic liberties—we all believe that's for every

person. But so act that the greatest benefit accrues to the disadvantaged. That sounds a lot like *epikia*, but I would maintain John Rawls does not give us a theory of justice, but only of fairness. “Justice,” he says, “is a social construction. It can change from time to time.” It will therefore not satisfy the criterion that I have just been talking about as a preordained, a pre-preparatory principle that goes before any plan that you decide. He would say, No, we’re constructed socially. That would take us away from the individual again. And, more or less, his theory is a procedure for fairness. It does not have a pre-precedent notion of justice by which you judge whether the distribution is fair.

Again, quickly in the background, what should medical care be? Should it be a commodity? That’s where we’re going today. Medical care is a commodity, as I said earlier, like beer and panty hose; its price, its distribution, its availability, its access all depend upon the working of the marketplace, the adulation of Adam Smith and the invisible hand of the marketplace. It’s going to straighten everything out. Well, unfortunately the marketplace does not have a heart, is not concerned about those who can’t be players in the marketplace, and persons who are left out of the marketplace are the ones I’m talking about, the ones who can’t be players. The marketplace also, as Adam Smith himself said, is not adequate for certain goods of society which are so important to the common good that they cannot be left to the vicarious action of this invisible marketplace.

So, it’s a legal right, it’s not a legal right, and even if it were, it would be minimalistic. It would not have within it the notion of a moral obligation. Legal is not always moral, although many people are trying to move us in that direction. If it’s legal, it’s moral, and you, doctor, should do it. I think it’s a very dangerous movement. The moral obligation of a good society is what I think we should be talking about rather than a manipulation of the system, rather than talking about the wonders of competition. Just think for a moment. All of you here know that you are a possible subject for a catastrophic event, even while you’re sitting here listening to me. Some of you who may be disaffected by what I’m saying will be developing deep chest pain and will need a cardiologist. Some of you may even fall to the ground with a stroke. (I hope not, not before the evening’s over anyway!) The point I’m trying to make is we’re always precariously balanced with reference to catastrophic events, and these are devastating. That’s why I’m putting my emphasis on the sick person and not the healthy person. Yes, I believe in the promotion of health, but I don’t believe in the cult of health, and there’s a difference.

In any case, what should medical care be? That’s another question you will have to answer. I’m coming back to you because eventually it is the American people and the way they see suffering, the needy, those among them who are ill, do we have any responsibility for them at all? Do we think justice is simply those who can pay or those who survive in a competitive? Or is justice *epikia*? Is it that modification of justice, justice without the blindfold?

The clinicians’ dilemma is: suppose we have a system, however it is justified, how do I apply the individual case, I’ve already introduced this notion, the commutative justice which covers what is owed in a relationship between individual persons, versus distributive justice which focuses on the whole society. What are the legitimate and illegitimate roles of the health professional? I think the health professional’s immediate role when he or she is locked in a covenantal relationship with the individual

patient, and by the way I'm talking about all clinicians who have promised to be of help, to be competent and to use that competence for the benefit of their patients, those are the persons I'm talking about. Well, if distributive justice is part of the larger system, and you're being told what the best way is to distribute health care, and you, doctor, or you, nurse, because you're at the point of distribution, it is you who spend the money. 75% of the expenditures are related to the doctors' orders, and you should be making your orders fit into a program of access where you save societies. How many of you would want to, when you're on the gurney or when you're in bed, would want to have your physician say to you the following? (which is what he or she would have to say to be honest): "I'll be happy to take care of you. What can I do for you? But you understand that I will be guided by, that it's my responsibility to preserve the resources of society." You hear this over and over again. If you take care of this person, this baby who has all of these problems, or this person who has all of these problems, you're depriving other people of health care. That sounds very attractive. It's a reality as a matter of fact, but from the moral point of view, our moral responsibility is with the one we've made our promise to, our act of profession. That's what the word "profession" means. It's not the way it's being defined today. Professionalism—certain attributes that make you attractive and useful to the patient—I think they're useful and I don't argue against those, but that's not the heart of it. The heart of profession is that you've made an act of profession, a promise, when you've said to the patient, "Can I help you?" And that implies acting in their interest and that implies, therefore, that you cannot bring into account what happens in access of the resources. The best contribution that we can make as clinicians to the economics of health care is to practice good medicine, and this is our failure. We are not practicing the best medicine we can, the most rational medicine. That's the problem on the side of the provider, but not to make him or her a rationer. That's going to only complicate the problem even further. That's an illegitimate role.

The legitimate role is to provide the best you can within a set of externally provided limitations. Yes, you might decide at St. Vincent's that you're not going to have program X or Y because you've looked at the allocation of resources within the realm of your own expenditures, but that's very different from saying to the physician, "Save us money."

Now, I said we will have to have rationing in any system, no matter how just you want to make it to be; in fact, to make it just it will have to be. So what are the criteria on a larger scale that any system of health and medical care distribution would have? Well, the criteria for ethical rationing, first, a true economic crisis. Can we demonstrate (I want you to answer these questions for yourselves today) that in America today our health care expenditures, even though they are large, are they creating an economic crisis in the sense of preventing us from obtaining the other good things in life that we believe are important like security, like safety, like environmental concerns, like education, like transportation, and so on? Are they creating a crisis in those other areas? Is health care really creating an economic crisis? I think one needs to ask that question, not in terms of the fact that I might have to pay something more to get justice, but rather, is there a true economic crisis? Have we exhaustive other methods? In my checkered career, I'm a clinician and always in touch with patients, I have been the chief executive officer of multimillion dollar health care centers, and I can tell you that they have not exhausted the

other methods, particularly on the administrative end of things. We pay more for the administration of health care in the United States than any of our civilized countries. Economists tell me between 25 and 30%. Have we exhausted the methods of dealing with the administrative overload? Third, what about the evaluation of our discretionary expenditures? You won't like this, but if you look at the way Americans spend their money, and I'm not being a prude or a blue nose, but on alcohol, on gambling, billions of dollars! Can we look in the mirror when people are not receiving care? And I'm emphasizing now the medically ill. Can we really look in the mirror and look at those expenditures and think that there's a fair relationship between them?

If we satisfy those first three criteria of a true crisis, exhaustion of other methods, saving money, and so on, evaluation, and that would of course mean practicing good medicine, and once again I do not want to exonerate the health professional. I can go into any hospital in this country and criticize the work up as being excessive and disorderly and wasting a lot of money. I try to find out how much that is. I don't get a good figure from anybody, but it's in the billions. Having satisfied those, we need a mechanism for public participation. Now the Oregon Plan, about which some of you know, had its defects. We need some way in which we can know what, in fact, the public does think it is willing to pay for. Public disclosure of the criteria for distribution of any of those services. The physician, I've already emphasized, is never the rationer, and an equal application of health policy to all and a mechanism to carry that out to all so that it is just—equals are treated equally, unequals are treated unequally, meaning that those who have the greater need get the greater attention.

Well, I just made some suggestions to you, some things for you to think about. The final question really is a question of what kind of a society do we want to be? Again this falls back on you. The politicians reflect what you think and what you will accept and what you will find tolerable in responsibility for your fellow citizens. Is there any notion of solidarity that we can refer to that has any sense that we are united to the rest of the members of our community? For at least those who are Catholics, does Thomas Aquinas' charitable justice not carry the day? And that does not have anything to do with the marketplace. The reverence for competition has not, as you well know, those of you who are dealing with health care expenditures today know, given us anything except increasing costs. Insurers haven't helped us. Do we need insurers? These are questions you need to look at as members of our society. I'll put back to you the final question: What kind of society do we want to be? And it will be reflected, as Samuel Johnson said a long time ago, in the way we treat the old and the poor and the sick and the disabled among us. Thank you very much.

Sulmasy: Thank you very much, Dr. Pellegrino. Now you really are on the hot seat, and we're going to ask Professor Steinfels to come up in a moment and start asking you some questions to unpack this a little bit.

We're delighted to have with us as the interlocutor here Professor Peter Steinfels who's co-director of the Fordham University Center on Religion and Culture. He's a university professor at Fordham. Many, many more of you know him as a religion columnist for *The New York Times*. He's the former editor of *Commonweal* magazine, he has previously been a visiting professor at Georgetown, at Dayton and at

Notre Dame; he has a PhD in history from Columbia, has written numerous books, articles and essays, and if you wanted a sort of paradigm of an educated medical lay person to ask questions of Dr. Pellegrino, I think the person you would pick would be Peter Steinfels.

Steinfels: Thank you very much, Dan. It's a great privilege to be participating in this event. It's a great privilege to be participating in any event with Dr. Pellegrino. There are many, many questions, obviously, that could have arisen from his remarks. You have that disarming, leisurely style that covered, in fact, an immense amount of material. I'm going to ask only a few questions. Part of them will not be aimed at putting him on the "hot seat" so much as giving him an opportunity, perhaps, to say a few things that he would've liked to have said if he had had more time to say them.

I would start with that final question that he posed to us: "What kind of society do we want to be?" And I would like to frame a question that actually, in a way, challenges and maybe opens up one of the basic terms that we've been using the whole evening, and that is "society." Plato and Aristotle framed their reflections on the good society in terms of a very small community. We live in a society, if we use that term, of 300 million people and have to think of criteria for health care reform and for health care systems, in terms of that size of a society. Actually, Dr. Pellegrino, you did refer to a smaller unit, primarily the dyad of physician and patient at the bedside. But I would wonder if you might take a moment to say something more about those other units? Families probably are the most outstanding, but there are other ones in terms of communities and so on. What place do they play in our ethical reflections on the criteria for a good health care system?

Pellegrino: Well, first of all, I would say, unless you start from a one to one relationship, which is really the final test of justice, of equality of any medical care system. That's the final basis. Now, I'm going to ask you to be more specific about what you think are those other units that are not taken care of, but before I do that, let me say that I'm always criticized for emphasizing the dyad, but everybody isn't ill. That's why I've turned it from "health care" into "medical care"—those who are needing it now. So as I see the society and the larger groups, first let me say that I think what Aristotle and Plato said, while it was within the framework, as you point out, of the polis, which was small, but you're looking at it politically rather than philosophically. What was true in the polis is true in this society as well. Circumstances have changed, yes, but I think if you were to practice that particular notion of justice, you would be laying the first foundation. The allocation of resources is a secondary question; it's when you decide what you're going to do with those resources, and I think people do it the other way around. Well, we've got security; we've got this, that and that. I'm saying that in a good society we ought to start with our needy, dependent human beings who cannot flourish without care. Now I don't think that that's changed. I happen to believe that human nature and things of global human nature are not different in the polis or in any other society of any size.

Steinfels: I think I would press you, then, on what other small units I had in mind. And I was also struck at the end of your remarks by your calling on the principle of solidarity which in Catholic thinking is often balanced by the principle of subsidiarity, or maybe not balanced, but I'm thinking of such things as religious communities and also such things as families which seem to me to play an enormous part in

actually developing any of the virtues, as sense of obligation or a feeling of compassion that are so tied to the actual provision of medical care for the sick.

Pellegrino: I'm beginning to grasp now a little bit better, I hope, the thrust of your first question. Of course, they have an enormous role to play... The religious community, one that's committed to the welfare of the sick by virtue of the matter of belief in its system. Certainly they would have a tremendous amount to do. The largest health care system in the United States outside of the Veterans Administration and so on is the Catholic health care system. And there are other religious groups who are, I think, orienting themselves in precisely the direction I'm trying to talk about. They are having financial difficulties being faithful to their commitment. So I don't discredit those at all, and I think they have an enormous role to play. For me, charitable justice makes more sense than simply a strict justice.

Now the point that you made, and it's very well taken, on the question of what happens to the family, what happens to the community—these are all very, very important issues, but in medical care, they can't function, as I said earlier, unless we are able to make our members flourish to the best of our ability. How can you have a good society, a good family?

Steinfels: Let me move on to another area which is your suggestion that there is a kind of division of labor between the physician and his or her bedside role, and whoever is responsible for the allocation of resources between health care, medical care, and other things that we value in the society. How do you see the relationship of the medical profession or the health professionals not at the bedside, but in terms of their contribution to that larger discussion of the allocation process?

Pellegrino: As the man said, a very good question, thank you. I think it's important that you asked that, Peter, and I think that I have written, even though I emphasized the dyad this evening, here are the four levels in which I think the physician has responsibilities, and the nurse as well. And the first level is, as I said, the covenantal relationship and commutative justice. At the second level is the thing we don't do, to participate in the public policy decision because I strongly believe if there is to be a rationing, it's not going to be set up by the health care professional; it's got to be set up socially; we should participate in that discussion, not as the people who say, "This is what you've got to do." The people who provide the expert input on whether, in fact, this is worth doing from the point of view of the impact on the patient. That's level two. Level Three, also an important responsibility, and at that level it's the participation of the physician as a member of a medical community. Medicine is a moral community, not existentially but conceptually. In other words, we physicians, and you nurses and other health professionals take an oath in which you declare that you are dedicated to something other than your own personal interest. That's rare in today's world. So therefore we should be active people moving the public debate to argue for the welfare of the person on whom the policy descends. That is a failure, a serious failure that professional organizations do not really act collectively for a moral issue. They will participate in the handling of the system, the manipulation of the system, etc... But to take the position that is a requirement, a moral obligation, we haven't done that. I think we have the responsibility to act as a moral community. Let me stop at this point by simply saying, envision what would happen if every physician in the United States joined with nurses and other clinicians and were to say, "These are the

things we believe are important, and this is what happens when you impose this policy on people who are on the gurney or in the bed.” At the fourth level, each of us as individual citizens should be participating in whatever we believe to be the appropriate way to approach this question. But at the third level it has to be the welfare of the sick person we promised to serve when we accepted our degree.

Steinfels: Finally, before Dan gets the hook out here so everybody gets a chance, I want my minute to be provocative, and since we actually met first during my brief career in the field of bioethics, I wanted to ask you about bioethics as a field. I have a two-pronged question. The first prong is deliberately polemical, and you can ignore it; the second prong is probably more serious. The first one, this is my Tim Russert moment. I’d like to quote something from a paper written for the President’s Council on Bioethics of which you are chair, but for this paper you don’t necessarily have any responsibility. It’s by Fr. Richard Neuhaus, and he writes about bioethics, “It is only somewhat cynical to observe the institutions with the greatest vested interest in dubious advances have recruited the best bioethicists that money can buy. One must acknowledge that bioethics as an intellectual institution is in significant part an industry for the production of rationalized, sometimes elegantly rationalized permission slips in the service of the technological imperative joined to the pursuit of fame and wealth.” So the first part of my question is, what is your reaction to that statement about bioethics? The second, more serious part is, what are your reflections on the overall trajectory of this field of which you’ve been recognized and honored as a founding father?

Pellegrino: On Fr. Neuhaus’s observation, I think for a significant number of bioethicists, what he says is true. Bioethicists are humans like everybody else, susceptible to the same drives that Aristotle pointed out—riches, honor, pleasures, power—and they may use their bioethics to those ends. I don’t think that’s acceptable. I think that’s wrong. Second, I do not regard myself as a bioethicist. I happen to have been alive before the field was invented and I happen to have been educated in philosophy and theology, and I therefore was concerned with ethical issues before bioethics appeared. So I think it has its limitations. There are very good people in it, honest people. There are also people, as in any group, in your profession as well as mine, I’m not going to argue that, but in both our professions, who are not faithful to the public responsibility of being a talking head.

On your second question, first I think the most interesting aspect of bioethics to me is the divergent course on which we find ourselves today based on two different world perspectives, and those world perspectives are at the foundation of major arguments in bioethics today—the questions on assisted suicide, abortion, stem cell research, and so on, go back to the conception one has of what it is to be human—what I call the anthropological question. Those who believe there is some source of morality outside of human, and those who believe there’s no such source. And those two are diverging increasingly as technology puts larger and larger questions before us which require research in what it is to be a human being—the fundamental anthropological question. I think bioethics is going to be with us. It’s a very important, powerful force in shaping public opinion, and my belief is that more and more people in the general public can be educated in bioethics. It is not, in my view, a set of pronouncements by experts who are a supreme court of answering ethical questions. I happen again to come out of a system of education that insists on a liberal education, and part of being liberally educated is the

capacity to make decisions about the right and the good, and to know how to examine ethical questions. Therefore, I think you ought all to participate because you are all affected by these decisions.