The Philosophical Society of Texas

PROCEEDINGS

1981

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PROCEEDINGS

OF THE ANNUAL MEETING

AT DALLAS

DECEMBER 4 and 5, 1981

XLV

AUSTIN

THE PHILOSOPHICAL SOCIETY OF TEXAS

1982

THE PHILOSOPHICAL SOCIETY OF TEXAS FOR THE COLLECTION AND DIFFUSION OF KNOWLEDGE *was founded December 5, 1837, in the Capitol of the Republic of Texas at Houston, by* MIRABEAU B. LAMAR, ASHBEL SMITH, THOMAS J. RUSK, WILLIAM H. WHARTON, JOSEPH ROWE, ANGUS MCNEILL, AUGUSTUS C. ALLEN, GEORGE W. BONNELL, JOSEPH BAKER, PATRICK C. JACK, W. FAIRFAX GRAY, JOHN A. WHARTON, DAVID S. KAUFMAN, JAMES COLLINSWORTH, ANSON JONES, LITTLETON FOWLER, A. C. HORTON, I. W. BURTON, EDWARD T. BRANCH, HENRY SMITH, HUGH MCLEOD, THOMAS JEFFERSON CHAMBERS, SAM HOUSTON, R. A. IRION, DAVID G. BURNET, *and* JOHN BIRDSALL.

The Society was incorporated as a non-profit, educational institution on January 18, 1936, by George Waverley Briggs, James Quayle Dealey, Herbert Pickens Gambrell, Samuel Wood Geiser, Lucius Mirabeau Lamar III, Umphrey Lee, Charles Shirley Potts, William Alexander Rhea, Ira Kendrick Stephens, and William Embrey Wrather. December 5, 1936, formal reorganization was completed.

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THE ANNUAL MEETING OF THE SOCIETY WAS HELD IN DALLAS ON December 4 and 5, 1981, the 144th anniversary of the organization's founding. It was in Dallas on December 5, 1936, that the formal reorganization of the Society took place. One of those responsible for much of "the rebirth" on that historic occasion was the longtime Society Secretary, Herbert Gambrell. To the joy and pleasure of the membership, Herbert was in attendance at the opening reception hosted by the Dallas Society members at the University of Texas Health Science Center.

The Saturday meeting on "Health and Medicine in the '80's" held in the Fairmont Hotel was climaxed with a dinner at the Dallas Museum of Fine Arts. Members enjoyed a rare treat with the opportunity to view an exhibition of master paintings from the collection of art connoisseurs Duncan Phillips and his artist-wife, Marjorie Acker Phillips. Members of the local arrangements committee under Margaret McDermott and the program committee headed by Bryce Jordan provided for those in attendance a program long to be remembered.

During the meeting President Charles A. LeMaistre announced the election of new members, William C. Harvin and Risher Randall, and announced the deaths since last year's meeting of members David Guion, Louis C. Page, Robert Gerald Storey, Jack Kenny Williams, and Andrew Jackson Wray. Four persons were named honorary life members for their contributions to Texas and to the Society: Mary Moody Northen, Claudia Taylor (Mrs. Lyndon B.) Johnson, Margaret Clover Symonds, and Dorman H. Winfrey.

Officers elected for the next year were Abner V. McCall, President; Leon Jaworski, First Vice-President; Wayne H. Holtzman, Second Vice-President; Dorman H. Winfrey, Secretary; and Mary Joe Carroll, Treasurer.

Attendance at 1981 Annual Meeting

Members attending included: Misses Cousins, Duff, Hartgraves; Mesdames Carpenter, Hill III, Johnson, Knepper, McDermott, Scott, Randall, Jr.; Messrs. Thomas D. Anderson, Andrews, Ashworth, Baker, Bell, Blanton, Blocker, Caldwell, Carmack, Clark, Coke, Cooper, Crim, Crook, Doty, Dougherty, Doyle, Fisher, Fleming, Galvin, Gordon, Gray, Greenhill, Hanna, Hargrove, Hart, Christopher M. Harte, Harvin, Heinen, Hershey, Hook, Jordan, Keeton, Kelsey, Kempner, Sr., Dan E. Kilgore, William J. Kilgore, Law, Lawrence, LeMaistre, Levin, Lord, McCall, McCorquodale, McGinnis, McKnight, Maguire, Matthews, Middleton, Miller, Moseley, Pressler, Randall III, Randall, Reavley, Richardson, Seybold, Sharp, Shirley, A. Frank Smith, Jr., Frank C. Smith, Jr., Sprague, Tate, Vandiver, Watkins, Wells, Gail Whitcomb, Dan C. Williams, Winfrey, Worden, Wozencraft, James S. Wright, Young.

Guests included: Mrs. Thomas D. Anderson, Mrs. Mark E. Andrews, Mrs. Rex G. Baker, Jr., Mrs. Henry Marsh Bell, Jr., Mr. and Mrs. Joe Belden, Dr. and Mrs. E. A. Blackburn, Mrs. Jack S. Blanton, Mrs. Truman G. Blocker, Jr., Mrs. John Clifton Caldwell, Mrs. George Carmack, Mrs. Edward Clark, Mrs. Henry C. Coke, Jr., Mr. and Mrs. Richard Collins, Mrs. John Cooper, Mrs. William Robert Crim, Mrs. William Crook, Mrs. Ezra William Doty, Mrs. J. Chrys Dougherty, Mrs. Gerry Doyle, Miss Beth Duff, Mrs. Joe J. Fisher, Mrs. Durwood Fleming, Mrs. Charles O. Galvin, Mrs. William Edwin Gordon, Mrs. John Ellis Gray, Mrs. Joe R. Greenhill, Mrs. Ralph Hanna, Mrs. James Ward Hargrove, Mrs. James P. Hart, Mrs. William C. Harvin, Mrs. Erwin Heinen, Mrs. Jacob W. Hershey, Mrs. Mary Collins Hibbs, Mrs. Harold Swanson Hook, Mrs. Leroy Jeffers, Mrs. Bryce Jordan, Mrs. W. Page Keeton, Mrs. Mavis P. Kelsey, Mrs. Harris L. Kempner, Sr., Mrs. Harris L. Kempner, Jr., Mrs. Dan E. Kilgore, Mrs. William J. Kilgore, Mrs. Thomas H. Law, Mrs. F. Lee Lawrence, Mrs. Charles A. LeMaistre, Mr. and Mrs. William Lewis, Mrs. Abner V. McCall, Mr. and Mrs. Harry D. McCament, Mrs. Malcolm McCorquodale, Miss Mary McDermott, Mrs. Robert C. McGinnis, Dr. and Mrs. James D. McMurrey, Mrs. Jack R. Maguire, Mrs. Harry J. Middleton, Mrs. Jarvis E. Miller, Mrs. John D. Moseley, Mrs. Herman Pressler, Jr., Mrs. Risher Randall, Sterling Robertson, Mrs. Lemuel Scarbrough, Lawrence E. Scott, Mrs. William D. Seybold, Mrs. Dudley C. Sharp, Dr. Gloria Shatto, Dr. and Mrs. Roy Shilling, Mrs. Preston Shirley, Mrs. A.

Frank Smith, Jr., Miss Connie Stark, Mrs. Willis M. Tate, Mr. and Mrs. Robert Trotti, Mrs. Frank E. Vandiver, Ms. Caro Walker, Mrs. Edward T. Watkins, Mr. and Mrs. Gerardo Weinstein, Mrs. Peter B. Wells, Dr. and Mrs. John Wheeler, Mrs. Gail Whitcomb, Mr. and Mrs. Tom White, Mrs. Dan C. Williams, Mrs. Dorman H. Winfrey, Mrs. Sam P. Worden, Mrs. Frank M. Wozencraft, Mrs. Mary V. Wozencraft, Mrs. James S. Wright, Mrs. Sam D. Young.

OLD PROBLEMS, NEW TECHNOLOGIES, AND CHANGING VALUES: THE CHALLENGE OF BIOMEDICINE

H. TRISTRAM ENGELHARDT, JR.

By assessing health and medicine in the 1980s, this meeting of the Philosophical Society of Texas has embarked on a major philosophical task. In comparing medicine and the law, it has begun to chart the interplay and the differences between major societal institutions. In exploring what societal resources ought to be committed to health care, and which of these resources ought to be invested in preventive, acute, or chronic health care, the Society is reassessing the ethical underpinnings of major practices in the macro-allocation of resources. In discussing modern medical ethics, it has recognized the importance of bringing into critical consideration the language of rights, obligations, and goals that structure health care. That such examinations are occurring now is not accidental. In my paper I will suggest some reasons why health and medicine have become the focus of modern academic and public policy debates. As such, I will be playing a familiar role for philosophers. I will be acting as a geographer of values, charting relations among ideas, societal viewpoints, and societal institutions. Though, as I will acknowledge, the problems we are now addressing are in many cases of ancient lineage, new knowledge and recent increases in power in medicine and the biomedical sciences have given those old problems new urgency. They have often altered what answers can be acknowledged as acceptable. Changes in our culture have made health and medicine problematic as philosophical issues, as issues which evoke major cultural and conceptual reexaminations.

Cultures are woven out of the interplay of values, passions, available natural resources, technologies, and peoples. All these forces and more intertwine in the rich weave of history. It is not as if technologies and sciences alone bear the stamp of the philosophical milieux in which they develop, or philosophies alone the stamp of the sciences and technologies of the cultures in which they arise. Each reciprocally influences the other.[1] When we come to consider our own place in history and attempt to reexamine our cultural foundations, as is occurring in part through bioethics, we do so because of an interplay of intellectual and practical urgencies, even if they may at

times be hidden. What one discovers in examining health and medicine in the 1980s is that many of the taken-for-granted moorings that bind beliefs and the sciences have been put under special stress. It is not hard to find the roots of that stress. We, as individuals living in a post-Enlightenment and to a great extent post-Christian era, find many of the traditional cultural certainties of the past shaken. Indeed, one finds that, at the very time that we are experiencing rapid technological changes with major influences upon our private and public lives, there are no longer generally convincing answers to many of the questions that these changes occasion, nor is there an orthodoxy imposed to give a semblance of cohesion.

This is but to say that the current problems in biomedicine exist in a secular, pluralistic society. That society, it should be noted, is transnational in character: it spans from America to Japan, and from Canada to South Africa. The bioethical problems of the industrialized West are the problems generally of our world culture, a culture without a single, concrete view of the good life, and yet with immense power to fashion particular understandings of the good life. We have never had more power and probably never had less sense of direction. Thus, as our culture comes to assess the significance of, and proper directions for, health care and the biomedical sciences in the 1980s, there is a sense of moral precariousness. However, it is worth noting that many of the questions raised are not new ones. These questions are as old as our Western reflective traditions. The issue of proper health care for private paying patients versus others is explored in the *Laws* of Plato;[2] and reflections on the propriety of abortion are older than discussions on the subject in Aristotle's *Politics*.[3] To recognize these as perennial questions is to understand that every generation must come to know its answers anew, for these questions bear on the very significance of human life and the purposes of major societal institutions. One would, therefore, expect to find the humanities charting ever again the answers to such questions as, "When do persons begin?"[4] "When do persons end?"[5] "When is it a good time to die?"[6] and, "How much of a government's budget should be invested in health care?"[7] To underscore the lineage of these questions with an example, one should note that the importance of health care, and the choice among allocations for acute health care, chronic health care, and preventive medicine, was the subject of a debate in Book III of Plato's *Republic*.

However, these perennial philosophical problems have become issues of pressing public policy concern because of the technological

power we now possess and because of our lack of moral consensus about the nature of the good life and the proper goals of health care. The issues to be discussed at this meeting of the Philosophical Society of Texas are for us inevitable. One cannot live in a pluralistic, secular society undergoing massive technological changes in the absence of an imposed orthodoxy, that is, as free persons, without these issues coming to the fore. There have over the last hundred years been extensive changes in lifestyle, technological abilities, and moral values. These have included a major commitment to supporting the free participation of individuals in societal institutions and in the fashioning of their own destinies. Only one step beyond abandoning the notion of the divine right of kings is the realization that no society or profession has privileges by divine authority, but rather through the consent of those involved. The authority of institutions has been recognized to be derived from the consent of those involved in them. This has led to the recognition of individuals having rights outside of and before any institutions. What one sees in medicine is in great part an attempt now to chart the consequences of a commitment to honor those rights in the institutions of health care.

Such charting of consequences, however, requires assessing alternatives and the competing costs and benefits of competing visions. This in turn requires critically examining different economies of values. After all, moral reflection attempts to guide us in determining what sorts of benefits can properly be achieved at what costs. Ethics, in attending to economies of values and of rights, seeks to discern their hierarchies and to indicate what values and rights should be subordinated to others and which ones should not be. A decision to give only a certain amount of funds to health care, and to allow the rest to be spent on such important things as philosophy, good wine, and food, involves a decision that the goals and rights to which such a choice commits one—including the right to dispose freely of one's funds in particular ways—are more important than the lives of the individuals who could have been saved had different choices been made. In such public policy choices, one is choosing among different senses of quality of life, or views of the good life, and therefore among different possibilities for death, suffering, and pleasure for different persons or groups of persons. It is *not* improper that we should so choose. Such choices are inevitable. Our moral obligation is to choose well. However, such choices are properly troubling. They

are made more troubling as our responsibility increases due to greater knowledge and greater power to effect change.

But, as I have indicated, just as our responsibility has increased due to greater knowledge and power, our sense of moral direction has been weakened. We are often unclear regarding how to use our greater knowledge and power. Think, for example, of our increased ability to determine fetal defects *in utero* and to abort defective fetuses. In choosing the ways to use such technologies, we choose among various sets of moral goals and obligations. It is here that the central moral challenge of bioethics lies.

The initial task is then to comprehend the significance of the choices. What, for example, are the alternative moral costs and benefits of different investments in preventive medicine versus chronic health care, a point, as I indicated, raised by Plato in the *Republic*. Moreover, how does one assess such alternatives, in the absence of a moral consensus? It is here that the humanist enters such reflections. That is, the humanist comes to reflect as a philosopher or bioethicist on the development of public policy precisely when the terrain of concepts and values is changing and unsure. This unclarity and unsureness should be underscored as characteristic of the modern perplexity, a point I have already alluded to. There are no longer many well accepted moral orthodoxies that are generally empowered to resolve bioethical disputes in public policy. Alasdair MacIntyre, in a splendid volume, *After Virtue,*[8] has argued this point by way of a general lament for ethics. He recognizes that as a consequence of the Enlightenment we are left with fragments of traditions regarding the nature of the virtuous life, but with no single tradition of traditions to give coherence and concrete guidance. I would amend his account on two points. First, I do not believe the condition is to be lamented. Rather, our condition is the result of the loss of what one might call the monotheistic presumption, the presumption that there will in the end be a single and univocal concrete view of the good life that ought to be embraced. In lacking this presumption, we resemble the Roman Empire with its acceptance of numerous gods and of competing views of the good life. This latter one might term the polytheistic presumption. After a period of over a millennium and a half we are returning to the notion that there may properly be radically competing views of the good life embraced within one nation, and that such is to the good of richness of perspective, and of toleration.

Second, I believe that there is indeed a tradition of traditions to which one may appeal. *Pace* MacIntyre, it can be drawn from the

Enlightenment. Indeed, it is precisely that element of the Enlightenment dream that inspired the founding of the Texian Republic. It was a view that one can, given the willing collaboration of free individuals, peaceably create answers even where particular moral answers cannot be discovered. Or rather, it presumed that one could create a peaceable fabric within which one could pursue whatever god or god surrogate one wished, as long as it did not involve direct harm to other citizens. One might think here of the phrase in the Texas Declaration of Independence, perhaps attributable to the chairman of the Drafting Committee, George C. Childress, which characterized the priesthood as the eternal enemy of civil liberty, the ever ready minion of power, and the usual instrument of tyrants.[9] I believe Childress is best understood here *not* as denouncing any particular priesthood, but as realizing that all post-Enlightenment republics would need to fashion a fabric of civil probity that did not presuppose a *particular* concrete moral orthodoxy. Essential to that fabric has been the reliance upon the free and informed consent of citizens and the provision for the choice of radically differing ways of life.

In such circumstances one finds, as one would expect, reliance upon free and informed consent as the lynchpin for moral medical practice and human experimentation. If it is not clear what one ought to do, or what one may constrain others to do, one must then leave such matters as issues of private choice. One attempts only to provide enough information concerning the difficulties at stake so that the individuals concerned may choose as prudently and as best as possible. Which is to say, if moral authority does not descend from the gods to anoint the republic, its authority, and that of other secular institutions, is derived from the consent of those who participate in those institutions. Mutual respect for the autonomy of moral agents becomes the necessary grammar for coherence in ethical disputes where a final answer cannot be discovered, but where instead provisional answers must be created. However, much that concerns the lives of individuals can then not be presumed to have been delegated to governments and other social institutions.

It is worth noting the radical depth of the realization of this point in the traditions of Texas. Texas, for example, sole among the Anglo-American jurisdictions, never held suicide to be a crime, nor, until a recent lamentable change in 1973, did it hold aiding and abetting suicide to be a crime.[10] All other jurisdictions had been influenced by the traditional notion that the state was the vicar of the Deity, the custodian of good public morals, and that the citizen as subject could

not quit his or her obligations to the state without the leave of the sovereign.[11] In contrast, even with regard to aiding and abetting suicide, the Texas courts held: "It may be a violation of morals and ethics, and reprehensible, that a party may furnish another poison, or pistols, or guns, or any other means or agency for the purpose of the suicide to take his own life, yet our law has not seen proper to punish such persons or such acts."[12]

In examining the position of the Texas Court of Criminal Appeals, it is useful to interpret it as having recognized two important points. First, it recognized the range of liberty that would need to be available in a society that did not form a single moral community, but encompassed groups with widely divergent views of the good life. Second, it recognized that individuals in such societies would be condemned to living in two-tiered moralities. The first is the morality of their particular communities of beliefs; the second, the morality of the general secular society that provides the peaceable fabric within which communities with divergent beliefs can live in reasonable harmony.

Bioethics has developed as a secular enterprise precisely as this second tier of morality. It has been fashioned as a logic of a pluralism, as a means for negotiating moral intuitions in a peaceable fashion among communities and individuals who hold often radically divergent views of the proper goals of medicine and of probity in health care. As such, bioethics is more a procedural ethic than an ethic with content. Free and informed consent, where the accent is upon the means of coming to a decision, not upon the content of the decision itself, is a good example of such a procedure. A modern pluralistic society is driven inevitably, in order to resolve the conflicts engendered by new technology and by divergent moral sentiments, to fashion a secular bioethics, which is often minimalist in the sense of being predominantly formal. An example is found in one of the greatest technological influences of modern medicine, namely, adequate contraception. Such technologies have, for the most part, been forwarded simply as an option, as a possibility. However, around that possibility, individuals have developed lifestyles that were in the past improbable, if not impossible. It is impossible to conceive of modern industrial societies in which women are full participants in the workplace and fully sexually active, and in which there are not rising population levels, without the contributions of modern contraceptive and sterilization techniques. One might think of the young married couple, each member committed to his and her own career,

and each sexually active, who have decided when in their careers they will have their one or two children.

This lifestyle is in part the result of modern medical science. It has also been tied to immense shifts in values. We have, for example, changed for most individuals the sense of what should count as natural or unnatural acts, and of why unnatural acts ought to be evil. In fact, we find that the moral frameworks and compositions of values in which a linkage of the unnatural and the immoral made sense to many of our ancestors now seem senseless, and in many points outrageous. To appreciate this, one need only compare most modern moral intuitions regarding the moral significance of contraception, with the view held by St. Thomas Aquinas, that the unnaturalness, which would be involved in some forms of contraception, would be morally worse than rape.[13]

These changes in conceptual framework concerning what ought to count as natural and unnatural, and of the moral significance of acting unnaturally, have acted synergistically with the technological advances that have been tied to the development of modern lifestyles. The result has been changes in human values as one finds reflected in the modern contraceptive ethos. But the point can be put more generally. We have come to see it to be virtuous to act unnaturally in the sense of constraining nature from its usual courses in order to enable the realization of the goals and purposes of persons in ways compatible with an interest in preserving elements of nature as a trust for future generations. We have come to see our own nature as one to be restructured and redirected not only through contraception but also through medicine and surgery, through the transplantation of organs and the implantation of artificial prostheses, through artificially conferring immunity against particular diseases, and through the possible applications of genetic engineering as well. This is a major shift in world view characterizing the modern era. It signals the body as an object for persons to refashion to fit their own purposes. It sets a distance between what we are as persons and what we are as humans.

This distinction between what it is to be a human versus what it is to be a person is an ingredient in many public policy decisions. One might think here of abortion or the use of IUD's to prevent the implantation of zygotes, where the human life to be lost is not that of persons and therefore to be tolerated.[14] One might think of brain-oriented definitions of death that allow one to declare persons dead, though human biological life continues. These points can also be put

more generally. The advances in medical technologies and sciences now make it possible for us to look at our human nature as something to be manipulated. After all, our present human nature is the blind outcome of selective pressures that have adapted us to environments in which we no longer live. We, therefore, as reflective persons, can—and in many circumstances must—judge which elements of this biological inheritance we are satisfied with and which we would wish to change.

But to talk of change is to recognize our new powers to effect change. And to recognize those powers is to acknowledge our new responsibilities. However, to acknowledge those responsibilities is to appreciate the ambiguity of acting responsibly in our current pluralistic societies.[15] We come, thus, as we consider the directions for health care and the biomedical sciences during the 1980s, to signal three leitmotifs that characterize our present moral condition.

First, we have amplified powers;

second, we therefore have increased responsibilities;

but third, our moral vision appears uncertain.

To this last point, yet another characteristic must be added: our realization that our resources are limited. Thus, just as our powers and responsibilities appear god-like, we are reminded of the very finite scope of our possibilities. We can only do some, not all, of the wonderful things we might wish to do. Hence, the attention in this program to the choices involved in the macro-allocation and in the micro-allocation of resources.

What then ought one to do? I suggest just what has been undertaken in this conference of the Philosophical Society of Texas. One must chart and reexamine in detail the consequences of the increased power and responsibilities of medicine in societies characterized by a pluralism of belief and a finitude of resources. We must now examine decisions that we could, to a great extent, ignore in the past. They were decisions we attributed to nature or to God. We can no longer avoid those decisions or the responsibilities they entail. Think, for example, of how increased genetic knowledge and capacities for prenatal diagnosis, coupled with effective contraception and abortion techniques, have made having a child an act of responsibility, not simply the acceptance of a child as a gift from God. For an interesting legal statement of this moral point, one might think of the recent California case of *Curlender* v. *Bio-Science Laboratories and Automated Laboratory Sciences* (June 11, 1980), which

suggested that parents should be held responsible for knowingly bringing to term a seriously defective fetus.[16]

In discussing these issues, one is not simply charting the present, but fashioning the ideas that will give tongue to the future. New solutions can be spoken only in the ideas and concepts that a culture fashions in reflections such as these. In participating in disciplined examinations of these issues as in this conference, one takes those important steps that lead, one never knows where, until new insights are born.

FOOTNOTES

[1]For an interesting and influential study of the interplay of facts and theories, which is suggestive of the nature of the interplay of ideas and technologies in medicine, see Ludwik Fleck, *Entstehung und Entwicklung einer wissenschaftlichen Tatsache* (Basel: Benno Schwabe, 1935). For an English translation, see *Genesis and Development of a Scientific Fact,* trans. Fred Bradley and T. J. Trenn (Chicago: University of Chicago Press, 1979).

[2]Athenian: ". . . You agree that there are those two types of so-called physicians?"

Clinias: "Certainly I do."

Athenian: "Now have you observed that, as there are slaves as well as free men among the patients of your community, the slaves, to speak generally, are treated by slaves, who pay them a hurried visit, or receive them in dispensaries? A physician of this kind never gives a servant any account of his complaint, nor asks him for any; he gives him some empirical injunction with an air of finished knowledge, in the brusque fashion of a dictator, and then is off in hot haste to the next ailing servant—that is how he lightens his master's medical labors for him. The free practitioner, who, for the most part, attends free men, treats their disease by going into things thoroughly from the beginning in a scientific way, and takes the patient and his family into his confidence. Thus he learns something from the sufferer, and at the same time instructs the invalid to the best of his power. He does not give his prescriptions until he has won the patient's support, and when he has done so, he steadily aims at producing complete restoration to health by persuading the sufferer into compliance." Plato, *Laws* 4.720b-e, in E. Hamilton and H. Cairns (eds.), *The Collected Dialogues of Plato* (Princeton: Princeton University Press, 1961).

[3]Aristotle, for example, argued, "On the ground of an excess in the number of children . . . let abortion be procured before sense and life have begun." Aristotle's *Politics VII,* in R. McKeon (ed.), *The Basic Works of Aristotle* (New York: Random House, 1941), p. 1302.

It is interesting to note that St. Thomas finds merit in Aristotle's having at least distinguished between early and late abortions. St. Thomas did not hold that early abortion constituted murder. See St. Thomas Aquinas, *Opera Omnia XXVI, In Aristoteles Stagiritae, Politicorum seu de Rebus Civilibus,* Paris, 1975, Vives, Book VII, Lectio XII, p. 484.

[4]For a discussion of this matter in St. Thomas, see *Summa Theologica,* I, 118, Art. 2.

[5]For a discussion of these points in the *Talmud,* see *Tzitz Eliezer,* 9:46 and 10:25:4, and *Yoma* 85a, Socino Edition.

[6]A classical exploration of this point is to be found in Seneca's 70th Letter on Suicide.

[7]Plato, *Republic,* Book III, 404-409.

[8]Alasdair MacIntyre, *After Virtue* (Notre Dame, Indiana: University of Notre Dame Press, 1981).

[9]The entire phrase runs: ". . . the army and the priesthood, both the eternal enemies of civil liberty, the ever ready minions of power, and the usual instruments of tyrants." The Texas Declaration of Independence, March 2, 1836.

[10]The precedent-setting cases were: *Grace* v. *State,* 69 S.W. 529, 530 (Tex. Crim. App. 1902), and *Sanders* v. *State,* 112 S.W. 68, 70 (Tex. Crim. App., 1908). The State of Texas criminalized aiding and abetting suicide in 1973. See, Texas Penal Code Annotated 22.08 (1974).

[11]William Blackstone, *Commentaries on the Laws of England* (New York: Augustus Kelley, 1969), Book 4, pp. 188-190.

[12]*Sanders* v. *State,* 112 S.W. at 70.

[13]St. Thomas Aquinas, *Summa Theologica* II-II, 153-154.

[14]For a study of the moral status of embryos and fetuses, and of such practices as abortion, see *Abortion and the Status of the Fetus,* W. B. Bondeson, H. T. Engelhardt, Jr., S. F. Spicker, and Daniel Winship (eds.) (Dordrecht, Holland: D. Reidel Publishing Co., in press, to appear in 1983).

[15]Many of these issues are explored in *New Knowledge in the Biomedical Sciences,* William B. Bondeson, H. T. Engelhardt, Jr., S. F. Spicker, and Joseph M. White (eds.) (Dordrecht, Holland: D. Reidel Publishing Co., 1981).

[16]*Curlender* v. *Bio-Science Labs. and Automated Lab. Sciences,* 165 Cal. Rptr. 477 (Ct. App. 2d Dist. Div. 1, 1980). In a dictum the court held that children could, under such circumstances, sue their parents. For a detailed analysis of tort for wrongful life suits, see Angela R. Holder's, "Is Existence Ever an Injury?: The Wrongful Life Cases" in *The Law-Medicine Relation: A Philosophical Exploration,* Stuart F. Spicker, Joseph M. Healey, Jr., and H. Tristram Engelhardt, Jr. (eds.) (Dordrecht, Holland: D. Reidel Publishing Co., 1981), pp. 225-240. The precedent force of this case has subsequently been set aside by statute: Cal. Civ. Code, Sec. 43.6 (1982). There has also been a contrary ruling in California, *Turpin* v. *Sortini,* 119 Cal. App. 3rd 690 (1981).

SESSION I

John D. Moseley chaired the Saturday morning session entitled "Modern Medicine: Can We Afford It?" He introduced Jarvis Miller, special assistant in the Office of the Governor, and Charles B. Mullins, of The University of Texas System.

MODERN MEDICINE: CAN WE AFFORD IT?

JARVIS E. MILLER

Mr. Chairman, I am indeed grateful to you and Dr. Jordan, program chairman, for the opportunity to be with you today. It is indeed a signal honor to be able to address this venerable Society with its illustrious membership and its rich history. In this country, we tend to take for granted the privilege of assembling and associating freely with the freedom to discuss and debate ideas, concepts, points of view. Having had the privilege of living and traveling abroad, I particularly treasure this occasion.

I approach my assigned topic today with a great deal of fear and trepidation. Let me say at the beginning that I am *not* an expert. I am merely one concerned citizen, a concerned citizen attempting to articulate in a crude, perhaps cumbersome way, a perception of a major problem of our society. I would begin these remarks by toying with the subject "Modern Medicine: Can We Afford It?" Perhaps a more appropriate question might be: "Can We *Not* Afford It?"

At present in the United States, there is a great deal of interest in the diseases and problems of advancing age. Perhaps that is a natural phenomenon. We have just concluded a decennial White House Conference on Aging, and there has been a great deal of publicity associated with it. The average age of key congressional leaders, almost by definition, would lead to interest on their part. And, if you will pardon a perhaps indiscreet observation today, the average age of those of us assembled here would be fairly high. We are, on the average, beyond the age where prevention, education and public health measures can contribute significantly more to our survival and the quality of our remaining years. The die is cast: our priorities now tend to be in the area of more drastic intervention to alter the course of events. We are looking to improved cardiac and cancer surgery, to

new medications and to new approaches to diagnosis, management and treatment. And we are concerned that these procedures enhance the quality of our remaining years, while at the same time lengthen them.

By all the usual and traditional criteria, we Americans are healthier now than ever before in our history. The number of senior citizens is rising rapidly. Diseases which formerly were mass killers are now at most minor problems in the total picture:

Diphtheria
Cholera
Tuberculosis
Poliomyelitis.

And death rates associated with some of the diseases of advanced age also have been declining, particularly the cardiovascular diseases and cancer. We now have more physicians than ever before, more hospitals, more sophisticated technology, and a wider, more sophisticated array of medications.

The Center for Disease Control (CDC) reported in 1980 that a child born then could expect to live 73 years, compared with 47 years for a child born in 1900. This remarkable change was attributed to improvements in sanitation, immunization and nutrition. CDC reported that the gain had been made possible primarily by a dramatic improvement in survival rates during infancy and early childhood, or in other words, prevention. Little came from health care in later years. But the CDC does not expect similar improvements in the next 20 years because Americans are not doing much about their survival rate in later years. There is still too much drinking, smoking, stress and lack of attention to nutrition. Added to that is the growing problem of accidents and crime.

On the other hand, Dr. Edward Brandt, Jr., the assistant secretary of health who is well known to all of us, was quoted yesterday as saying "The level of health in this country is good and getting better. . . . Society's very success in keeping people healthy and permitting them to live into old age is putting great stress on the nation's health care resources." He went on to say: "Smoking is at its lowest level since 1945; more adults than ever are having their blood pressure checked; more women are being examined for breast and cervical cancer; more people are physically active and are watching their weight and diet."

The fact remains, though, that we still have serious health problems and issues in this country. When I was in Lubbock recently, the retired county health officer brought to my attention widespread

problems of maternal and child health, particularly among young minority women. There are serious questions about the quality and availability of health care in many areas of the state. On the one hand, there is the cost of health care, both to the individual and to society, and the individual's right to adequate health care; and, on the other hand, there is personal responsibility for consequences of individual choices of lifestyle. Another problem of unknown dimensions is the impact of environmental pollution and degradation on our future well-being.

Dr. John H. Knowles, late president of the Rockefeller Foundation, writing some ten years ago put it this way:

> Our acute, curative, scientific and technological (medical) service is unexcelled anywhere in the world. Our prevention and rehabilitation services and our extended care and nursing home facilities are dismal. In other words, high-cost medicine is the best, while low-cost services and those with high benefit to cost advantages remain grossly underdeveloped.

Albert Rosenfeld, writing in *The Saturday Review* in December, 1974, had this to say:

> Much of medicine today consists of heroic and spectacular forms of therapy that excite—and deserve—our admiration. We rescue many victims of maladies formerly deemed hopeless. We perform hours-long triple-bypass operations on their failing hearts and provide cardiac-intensive care. We dialyze them on artificial-kidney machines, transplant vital organs, then suppress their immune systems in order to keep the foreign grafts from being rejected. We surgically excise not only cancers but also large quantities of tissue suspected of harboring cancer cells, then give massive doses of radiation and administer powerfully poisonous chemicals. We implant synthetic parts, which can be monitored electronically at long distance. The catalog of lifesaving strategies is long and impressive.
>
> But all of this marvelous technology requires costly upkeep, elaborate facilities, complex machinery, and highly trained and dedicated personnel. If we continue in a similar fashion, by the end of the century we will find ourselves spending an enormous portion of the national budget just to keep sick people alive from one day to the next.

As Rosenfeld points out, something simply must be done. We cannot continue on our present course.

Health care expenditures in the United States increased at a rate of slightly over 12 percent annually between 1965 and 1980. During the same period gross national product increased only 9.2 percent. In 1980, total health care expenditures were $227.7 billion (up 13.7 percent from 1979) compared with $42 billion in 1965 (the year in which Medicare and Medicaid legislation was enacted). If recent trends continue, economists predict that national health care costs will reach 10.5 percent of GNP in 1985 (in 1980 health care costs were 9.2 percent of GNP). Over 25 percent of these costs is paid by Medicare and Medicaid. Approximately 45 percent of health care costs is paid by other third-party insurers (Blue Cross/Blue Shield and commercial carriers).

And, because government, both federal and state, is so heavily involved in the field of health care, any discussion of the subject must at least consider some of the ways in which government is involved and assess its appropriate involvement in the future. Some of these areas are:

Prevention, particularly through provision of educational services and public health programs and services.

Education in both the medical and allied health fields, as well as in other relevant fields such as nutrition, food quality and safety and the basic sciences.

Research and development and fostering adoption of new approaches and techniques.

Regulation, particularly through licensing, food and drug safety, quality of care and services, and cost containment processes.

Facility development financing.

Financing of medical care and health delivery services.

Primary care assurance of equity in health care delivery system.

Charles R. Wolfe, writing in the *Wall Street Journal* in December, 1981, stated the case for equity very well:

> A recent article in the *New England Journal of Medicine* pointed out that approximately 35 percent of the hospital care dollar was used by 13 percent of the patients, and there was a very high association of these high-cost patients with obesity, diabetes, heart disease (gluttony), lung disease (smoking) and cirrhosis of the liver (over-drinking). In effect, since 10 percent of Americans will be admitted to a hospital per year, 1.3 percent of Americans accounted for 53 percent of the hospital care dollar. This only accounts for

> the chronic effects of these habits and says nothing about car accidents, etc., related to drinking and drugs.
>
> Since I am charged for these indulgences, why can I not insist on those who indulge paying higher health care premiums, higher taxes, higher Medicare fees and higher life insurance premiums?

A number of trends in government involvement in health care in the United States can be discussed. Above all, we can state that there has been an increasing tendency to improvise. Public policy has shifted because of political and social developments. But, lacking in the process has been any semblance of effective, well-defined long-range goals and objectives in health policy. Parenthetically, let me state that this is not unique to the field of health care. Rather, it characterizes our basic political/governmental philosophy. The absence of well-defined goals and objectives inevitably leads to shifting, changing policies and improvisation.

A second trend is increasing government involvement resulting from desires to alleviate social ills as well as to cope with the increasing sophistication, complexity and, consequently, costs of health programs, facilities and treatment.

With respect to costs, there has been increased emphasis on both benefit/cost analysis and its application in the field of health care and on cost containment.

Some interesting trends are evident in the composition of American medical costs during the last decade:

	1970	**1980**
Hospital Care	38%	43%
Physicians' Services	20	20
Drugs and Medications	11	8
Dentists' Services	6	7
Nursing Home Care	4	9
Construction	4	2
Research and Development	3	2
Other Services and Expenses	14	9
Total	**100%**	**100%**

Nursing home care increased dramatically, doubling its relative importance. Hospital costs increased from 38 percent to 43 percent. Declines in relative share were noted in drugs and medications, construction, research and development and other services and expenses.

Currently, about 60 percent of total personal health care cost is privately financed, while 40 percent is publicly financed. Nearly 56 percent of hospital care is publicly financed, while 44 percent is privately financed. Nearly three-fourths of the cost of physicians services is borne by private sources, while slightly more than one-fourth is publicly supported.

While we lack adequate data on expenditures for health care in Texas, several bits of information are enlightening:

. . . Between 1974 and 1981, medical expenses paid by the Texas Department of Human Resources (DHR) increased 2.8 times, from $440 million to $1,250 million.

. . . In the DHR program, the in-patient hospital cost per patient per day between 1974 and 1981 increased 4.6 times, from $93.79 to $427.63.

. . . State appropriations to the state's health science centers (and associated medical schools) between 1974 and 1982 increased five-fold.

The number of physicians and medical education are issues which have come into the public policy arena in recent years and obviously will continue to receive attention in the years ahead. By 1990, the total number of physicians in the United States will increase by nearly 40 percent. After anticipated population growth is considered, the number still will increase by 30 percent per capita.

The Graduate Medical Education National Advisory Committee in 1980 projected an *excess* of 70,000 physicians by 1990. Obviously, any projection of this nature is relative. There are those who would assert that there would be no surplus if services were made available to all in need.

Numerous studies have shown strong, positive association between the supply of physicians in a given area and expenditures for health services. For example, in 1970 John P. Bunker of the Stanford University School of Medicine found that the total surgery rate in the United States was about twice that of Britain, where there are considerably fewer surgeons. A 1973 study of the American College of Surgeons showed a similar relation in regions of the United States. Some of the reasons advanced for this are the fact that:

1. Physicians make greater efforts to keep busy through prescribing more office visits, more tests, more surgical procedures and a greater use of marginal medical and surgical procedures.

2. The increase in specialization and the increase in referrals.

3. A substitution of physicians for other health professionals. For example, it is reported that, in the field of dentistry, increased numbers of dentists are doing work formerly performed by dental hygienists.

On the other hand, there is a body of thought that holds that the increased supply of physicians can lead to lower costs of health care because:

1. Specialists might do a better job of diagnosis, thus allowing earlier, more precise and hopefully more effective treatment.

2. Employment of greater numbers of physicians in salaried positions such as health maintenance organizations might increase efficiency and lower risk, thus contributing to lower costs.

3. As physicians compete more aggressively for their share of the total medical dollar, they might gain share at the expense of hospitals.

Columbia University recently published a report of a conference on health resources. It stated:

> Many participants saw a general deterioration in the status of the profession, with government taking an even greater role in determining standards of medical education, licensing, scope of practice, and quality of practice. It was unclear, however, whether these predicated changes were primarily a result of present and forthcoming increases in physician supply. Many also saw the internal ethics of the profession changing, with marketeers becoming the preeminent physicians.
>
> It was unclear to most of those present how either the profession or government could do much to affect the numbers, if they decided this would be desirable. The pipeline for physician production is very long and those entering medical school in the fall of 1981 will not be completing residency until July, 1988, at the earliest. Changes in admission policy implemented now could not affect the physician supply before 1990. *Medical schools will not take the lead on this issue.* Specialty societies and other arms of organized medicine have not thus far included on their agenda attempts to limit the supply and they are reluctant to introduce them now.
>
> Much of the future change in supply will not be due to deliberate policy, but will be the indirect effect of policies designed to resolve other issues. Students may begin to avoid medicine as a career choice, although there is currently a healthy excess of applicants over places in U.S. allopathic

> and osteopathic schools. The payoffs (financial and otherwise) of a medical career are perceived as declining, and the costs of entering the profession are escalating rapidly, especially with tuition rising at the same time that loan and scholarship support is declining. Eventually, this should have some effect on the supply of physicians.
>
> Pervading the conference was a generalized set of tensions within the medical profession and medical education that have been activated by the manpower issue. The leadership of the organized profession are to varying degrees concerned with the implications of an increasing supply, possibly a surplus, for medical practice and ultimately for the profession, and debate the need to develop a policy stance. However, within academia, where intervention—if it were decided upon—would be implemented, faculty and administration are indifferent to the question of supply, and indeed social issues generally, except as they impinge upon the customary activities of medical education. Forces outside the profession inhibit definitive action as well: the fear of arousing public hostility and the threat of violating antitrust legislation. The result has been perpetuation of the policies of the '60s and '70s, and reluctance to seize the initiative in confronting the manpower realities of the coming decade. On the other hand, changes in manpower policy will inevitably be made—if not directly, then indirectly; if not by the profession, by others, most probably government, whose perceptions and imperatives may be antithetical to those of medicine. The erosion of other aspects of professional self-government will inevitably follow. . . .
>
> The future of the field will be determined by others in addition to physicians and medical institutions, and other issues compete with physician manpower. How all these interacting, often conflicting opinions, power centers, and policy choices will sort themselves out is not at all certain; the only certainty is that changes in medical practice over the next decade will exceed those of the recent past.

In conclusion, let me venture the prediction that the debate over the economics and cost of medical care in this country will continue and even intensify as its share of gross national product increases. Public policy debates will become even more interesting, and we may even be able to prod society and the individual to recognize the important role that each individual plays in determining the amount of

health services used. To return to the words of John H. Knowles who, writing on responsibility for health, said:

> The individual must realize that perpetuating the present system of high-cost, after-the-fact medicine will only result in higher costs and greater frustration. The next major advances in the health of the American people will be determined by what the individual is willing to do for himself and for the society at large. If he is willing to follow reasonable rules for healthy living, he can extend his life and enhance his own and the nation's productivity. If he is willing to reassert his authority with his children, he can provide for their optimal mental and physical development. If he participates fully in private and public efforts to reduce the hazards of the environment, he can reduce the causes of premature death and disability. If he is unwilling to do these things, he should stop complaining about the rising costs of medical care and the disproportionate share of the gross national product that is consumed by health care. He can either remain the problem or become the solution to it; beneficent government cannot.

SESSION II

Thomas M. Reavley served as chairman for the session entitled "Personal Responsibility for Personal Health." Speakers for the session were Lauro F. Cavazos, president of Texas Tech University and Texas Tech University Health Science Center, and Charles C. Sprague, president of The University of Texas Health Science Center at Dallas.

HOW SHALL WE EDUCATE THE LAYMAN CONCERNING THE MAINTENANCE OF HEALTH?

LAURO F. CAVAZOS

I am pleased to meet with you today, but I am somewhat overwhelmed by the topic assigned me. I have been asked to address the question of how to educate laymen concerning maintenance of health. If I really knew the answer to the question I would surpass Socrates in wisdom, have the combined knowledge of all the professionals working through the World Health Organization, and be able to reduce medical costs by billions.

So, I must start with the confession that I don't know how we shall educate laymen—or even medical doctors, for that matter—on the maintenance of health.

If, as John Ruskin has said, education means teaching people "to behave as they do not behave,"[1] good health education should be able to convince all the world to quit smoking; moderate alcohol, sugar and fat intake; drive with caution; exercise faithfully; and follow physicians' instructions to the letter.

While you and I both know that to achieve that kind of behavior modification would solve a multitude of health problems, none of us has a pat answer on how to proceed with lay education. Preventive health care, however, is an idea whose time has come—or, perhaps, returned.

I say *returned* because our pioneer forefathers and even our not-too-distant rural society had to rely on preventive practices to a much greater extent than we depend on them today. The life span was briefer, but preventive measures and common-sense remedies saved lives in remote households.

I remember growing up on the vast King Ranch where we had access to professional medical help—but certainly not the easy access available today. In the Cavazos household, when I was growing up, I can tell you that there was no question of daily exercise. We had that in the work required of us. We had basically good nutrition. Our isolation gave us only a limited access, even as teenagers, to cigarettes and alcohol. When it came to fresh air and sunshine, we had it in abundance. And our lifestyle was common in this country a half century and less ago.

Rapid changes, however, are affecting more than the United States and other industrialized countries. They affect the Third World. William Foege of the U.S. Public Health Service reports that—while infant mortality rates are decreasing and safe water sources increasing worldwide—the Third World is becoming burdened with many of our own health problems:

> Occupational hazards due to chemicals and injuries are increasing at a predictable rate. Rates of cigarette smoking for much of the Third World now exceed the rates for the United States. All too often, [World Health Organization] plans for 'Health for all' by the year 2000 ignore the fact that in the year 2000, health problems of the Third World will be the health problems we now face in the United States, with the effects of cigarette smoking ranking at the top.[2]

Foege's observation is discouraging but only touches the surface of the very complex Third World health problems. Studies in developing countries show us that access to health services is uneven. Large numbers among the rural population have no access. Health facilities and personnel are concentrated in urban areas but there the newly arrived poor are often neglected. There is a shortage of skilled health personnel. There are great deficiencies in management. Available technologies are either inappropriate to the circumstances or are expensive. And, in many of these Third World countries, there appears no real political commitment to apply resources where the need is greatest.[3]

The question we must ask is, who cares? Should we concern ourselves about health care in the Third World? Have we not enough problems of our own? Again, I would like to give you Foege's answer which comes "through the centuries from many sources and many cultures." In our own culture, it is commonly called the Golden Rule. Foege puts it this way: "Over and over, we are reminded that how

we treat others becomes the measurement of a civilized society, or a civilized person."

He further points out: "The more geographically remote the target of a public health or prevention program, the more difficult it is to develop interest, mobilize resources and carry out such a program. When the beneficiary actually lives in another country, the difficulties are multiplied. Only civilized societies support such programs."[4]

It is true that the immediate beneficiaries of an overseas program are the people who are healthier as a direct result of that program. But there are other beneficiaries—economically, mentally and socially.

Let's look at a fairly simple example—the red, imported fire ant that poses a relatively slight medical hazard. The ant, from the heartlands of Brazil and Paraguay, was unknown in the United States until forty years ago when it first appeared in Mobile, Alabama. Its range has now stretched to San Angelo, Texas. The Mediterranean fruit fly, certainly not native to California, has caused an agricultural and health uproar throughout the Southwest, with some prominent commercial repercussions in Japan. Measles, unknown to the American Indian, was brought here by the white man and caused devastation among native Americans.

Smallpox, through massive, coordinated efforts of the World Health Organization, has been wiped out. We all feel safer because it no longer threatens any of us.

With worldwide transport and travel as easily accomplished as it is today, can anyone say world health is not a matter of enlightened self-interest? It cost money to wipe out smallpox, but was not the investment an excellent one? The introduction of Sabine oral vaccine to prevent polio was costly. I ask you, was it worth the cost? Is it not cheaper to prevent polio than to construct and staff—as we were constructing and staffing—polio treatment centers?

The cost of medical care in this country today is more than $240 billion[5] annually and rising. Medical progress has its great blessings. Yet the sophisticated and rapidly improving equipment and the highly specialized medical teams come with big price tags. Equipment is obsolete almost as soon as it is installed. Medical specialists are in constant training to keep pace with new knowledge.

Real benefits received certainly merit high costs. On the other hand, we are all seeking ways to bring costs down. The best way is prevention. Prevention can bring down insurance rates. Prevention can bring down out-of-pocket dollars you and I spend—more than

one thousand dollars per capita in the United States[6]—and, in contrast, about one dollar per capita in Ethiopia and some others of the world's poorest nations.[7]

Prevention begins, of course, with our individual concern—with our own, personal education. It must, if it is to be effective, extend to all in need in well-managed, properly funded programs planned with great care.

The director-general of the World Health Organization points out that economic development and health are indivisible.[8] This holds true on a global scale but also on a national and community scale. The key, to a great extent, however, lies in carefully considered and wise allocation of available resources.

Smoking—called by the Surgeon General "the single most preventable cause of death"[9]—alcohol and drug abuse, reckless driving, and poor nutrition are all health hazards invented by man. They are hazards that affect rich and poor alike. If you think the unemployed alcoholic or drug abuser in Detroit is really none of your concern, wait until you meet him on the highway as he travels into the Sunbelt looking for a job.

If you think an impoverished family's infant, suffering from metabolic disorders in a Houston ghetto is no concern of yours, wait until you pay the taxes to support that mentally retarded individual in a state institution for life.

We are close to, but have not yet reached, the feasible goal of protecting all American children from many serious diseases and the permanent physical and mental handicaps those diseases can cause. We have available effective immunization. But we also have complacency. We have gained in the past few years, but we will succeed only with sustained national and local campaigns that create parental awareness and insist on the use of the available remedies.

The subject we are attacking today is far too broad to touch on all the health matters that should concern us. We know there are ways to cut the risks of heart disease and cancer. We know we need to attack with full force the appalling incidence of child abuse with its terrible consequences. Many of the problems—both physical and mental—of the aging are not at all insurmountable. It is important, however, to look at the means to rescue ourselves through education.

The first step might well be to attack an unrealistic attitude that I see permeating all of society. In regard to our health, we tend to know more truth than we want to accept.

We receive massive doses daily of health education. But we could term much of it reverse education.

For instance, if telling people were all it took to make everyone in the United States take care of the teeth, we would all be well educated. The minute we flick on a radio or a television set, we are "educated" in regard to tooth care. We are, in fact, beset with a wondrous variety of admonitions—to take a capsule or pellet to hide our cold symptoms, follow four out of five doctors in our choice of headache remedies, caress our bodies with soap—for softness if not for cleanliness, make ourselves kissable with mouthwashes, fall asleep with a pill, and pep ourselves up with coffee or a soft drink. We watch country music audiences sit with a glass of wine to sip. And we all know that a good day's work should be rewarded with at least a can of beer.

The electronic education affects all of us, from the very young to the very old. Americans spend more time watching television than doing anything else except sleeping—and some even cut short their sleep to watch.

University of Pennsylvania researchers, reporting in the October issue of the *New England Journal of Medicine,* found that daytime serials—playing to audiences estimated at 55 million—may well be "the largest source of medical advice in America." Health is the most frequent topic of conversation on these programs, and almost all the action is, indeed, talk.[10]

In movies and in broadcast serials, doctors—mostly male and almost all having mystical powers—perform miracles. Heroes and heroines seldom die—no matter how horrendous their afflictions. So our young people—and we, ourselves, to some extent—believe that death probably will pass us by if we align ourselves with the "Good Guys."

Police and thieves enter into mad chases by motorcycle and car—without seat belts, of course. Occasionally the "Bad Guys" crash and burn, but heroic officers survive the adventures to pursue other malefactors at wildly breakneck speeds in next week's episode. "Good Guys" escape the laws of physics.

We witness torrid love scenes, but none of the participants ever feels threatened by venereal disease. The danger—however present in real-life—is not part of the plot. And we wonder why 75 percent of all reported sexually transmissible diseases occur among young people between the ages of 15 and 24.[11]

Researchers found television's mentally ill to be unpredictable, dangerous and sinful, pulling the public away from the image of the experts and toward traditional prejudice.

In prime-time programs and commercials, there are more references to beverages—particularly alcohol—and to sweets in programs than in commercials. In crime and adventure programs, 48 percent of the women and 41 percent of the men drink, but only 1 percent have drinking problems or alcoholism. In daytime serials, alcohol-related events occur at a rate of about six per hour.

And what about weekend children's programming? The Pennsylvania researchers found that 18 acts of violence occur each hour, but only 3 percent of the victims require treatment. For adults in prime-time dramatic programs, grabbing a snack—39 percent of all eating-drinking episodes—is almost as frequent as eating a regular meal—42 percent. But in weekend, daytime children's programs, snacks go up to 45 percent and regular meals decline to 24 percent. Sweets and non-nutritious (junk) food predominate. The snack food is fruit only 4 to 5 percent of the time.[12]

It is, of course, unfair to limit our slings and arrows to the magic of electronics alone. Bookstores are full of the same fantasies in print. In addition there are the health books and the magazines. We can learn to run, to diet, to apply all manner of questionable remedies to cure our malaise or our true maladies.

The degree to which the self-appointed expert authors are all-knowing is, indeed, astonishing to the world of scientific medical research where answers are still being sought. We know much—but not enough—about obesity and even about exercise. Otto Appenzeller of the University of New Mexico School of Medicine tells us that we still do not fully understand the physiology of jogging or running. We cannot even "explain the complex behavioral sequences that induce millions to exercise daily and to justify what until recently has been considered bizarre behavior in the endurance-driven amateur athlete."[13] We are further urged through magazines to purchase guns and boats and high-powered motorbikes without any regard for safety education. Should we wonder why, in 1977 alone, 100,000 Americans lost their lives in accidents and 50,000 of those in motor vehicle accidents?[14]

And with all of this powerful mis-education, probably our greatest weapon of destruction could be examples we set for our children and the young people around us.

Do we smoke and call it tension release? Do we reach for a drink to relax? Do we expect the doctor to prescribe a pill to relieve any feeling of depression? Do we get enough sleep and enough exercise? Do we demand well-balanced meals? Do we discuss what we view and hear during the day? Do we try to bring any reality to the unreality of our world of print and film?

Do we face up to the honest truth that medical miracles cannot cure our self-imposed health abuse? Medical care can help, but it cannot reverse a lifetime of abuse. The laws of cause and effect have not disappeared—but are we convincing our children that this is so?

The best health promotion begins at home. The surest way to prevention is in childhood education—in the home, the schools and the community.

Health educators tell us that young people who gain an understanding of how body systems work and how their personal choices affect their well-being are prepared to make wise choices for their own health care.[15]

You who are parents might very well understand when I say I'd like to endorse the advice of the wiseacre who contended that a child be told: "Do it because I say so. I'm bigger than you are and it's my house." The only trouble is that pretty soon the child is bigger than the parent and is completely incapable of making a decision because there has been no opportunity to practice and learn.

The art of good decision-making is the basis of education that teaches people to "behave as they do not behave." It is an art that can, indeed, be taught to adults. The education is more effective, however, if the art is learned as a child.

Let me give you a couple of examples.

Our Surgeon General has reported one effective program that was used in Finland, which has the highest documented heart disease rate in the world.

In the province of North Karelia, more than half the men smoked. They also had elevated cholesterol levels, and they consumed a great deal of animal fat and dairy products. Untreated hypertension was common.

In the early 1970s, the province developed a massive health promotion campaign designed to help 180,000 inhabitants control blood pressure, reduce cholesterol intake and stop smoking. Industries promoted low-fat dairy products and low-fat sausages. Local residents were trained as health personnel. There was extensive media coverage.

After five years, the province reported an 18 percent drop in cigarette smoking among men aged 25 to 60 and a 15 percent drop in smoking among women. Butter consumption fell, and 50 percent of the population was using low-fat milk. The number of men with high blood pressure declined by 27 percent. The decline was 49 percent among women. Early results showed a drop of 17 percent in heart attack incidence and a 33 percent drop in the incidence of stroke among men in that province.

Massive doses of education helped repattern lifestyles among adults in North Karelia Province. The result was health protection.[16]

Another more recent study in California is reported in the *American Journal of Public Health.* Researchers studied what they called "Heart Healthy Eating and Exercise, Introducing and Maintaining Changes in Health Behavior." For brevity, I refer only to the nutritional study.

The concept was to change elementary school children's habits as a key element in promoting widespread adoption of a healthier lifestyle that could lead to a reduction of cardiovascular risk behavior and disease. At the same time the researchers hoped that, in working with children, adults might also benefit. Families involved were above the national average in education and income.

Students were taught, among other things, how to recognize heart-healthy foods, shop for them and prepare them. They learned how to ask parents to buy recommended foods, to serve them and pack them in lunches. Goals were set; feedback and reinforcement were used with graphs depicting progress and red heart stickers dispensed for heart-healthy lunches. Educational meetings were held with researchers, teachers, principals and parents. Following summer vacation, teachers held booster sessions to encourage additional nutritional change.

Trained observers watched students, particularly at lunchtime, and throw-away food trashed by students was recorded.

Results of the study showed close to a 40 percent increase in heart-healthy food in children's lunches at the end of the program. Even after the summer vacation, the percentage of the better food in lunches measured slightly over 30 percent.

When asked to estimate the importance of the program, 88 percent of the students, 67 percent of regular classroom teachers and 63 percent of the parents rated the program very important.[17]

This California study has more importance than instruction in heart-healthy foods, however. Children were taught how to make

decisions that could affect their present and future health. They were not forced to bring certain foods in their lunches, and they were not forced to eat what they brought. What they consumed had better nutrition, however, and they learned to choose healthier food.

There is yet another lesson to be learned from this study. Researchers structured the program to the children's situation. When we are engaged in education for health care and health promotion, our programs must be appropriate to local conditions and a reasonable level of acceptance. The Finnish program would not be suitable for California school children, nor would the California program be effective in Finland without adjustments to meet cultural and age differences.

Of course, any discussion of health promotion or health care involves economics, but more money alone will not achieve any of our goals. On a local, statewide, national or international scale, resources must be allocated to be cost-effective.

In developing countries, studies indicate that highly trained physicians and surgeons tend to concentrate in the large cities or to emigrate. One need there is to train great numbers of less skilled health workers to deliver services to the urban and rural poor with the highly trained professionals fulfilling essential management and supervisory roles.[18]

It is difficult for us, in this country, to understand the health care needs of developing nations. Many of these, however, are confronted with bringing their services up to our level—but starting where we and the European countries were two hundred years ago. They are in need of safe water and sanitary conditions. They are in need of great educational campaigns to prevent disease. They also are in need of environmental protection and defenses against the introduction of man-made deterrents to good health.

In this country, federal financial help in any new educational program is unlikely, but not all programs need dollars as much as they need concerned individuals to volunteer to help map programs and carry them out. Meals-on-Wheels for the elderly and the handicapped requires money for food and preparation, but volunteers provide the wheels. The program is effective. Recipients benefit nutritionally and from a mental health standpoint. Meals-on-Wheels is also an excellent example of cooperative work.

There can be economies we have not yet explored. Health care agencies—particularly in these tight money times—need desperately to take more responsibility for working together. All of us engaged

in any aspect of health care delivery need to sit down together to try to reach common commitments and goals. We should not work at odds with one another, nor should services overlap. There is economy in good management on the voluntary as well as the business level.

We should set goals and then devise the best systems or programs for reaching those goals. Our goals should be reasonable and the methods for reaching them should be well planned.

We usually get aroused to the cause of disease prevention when we perceive a threat to health or when we recognize a disease or some hazard in the environment. Because we are aroused, we tend to rally to prevent disease and to protect as many people as possible from threats to their health. There are marches and rallies, and angry shouts are exchanged. But what goal are the marchers trying to reach? What plan do they have to reach the goal?

Prevention of illness and promotion of health should begin with people who are healthy, and the planning should begin long before a threat is imminent.

Our well-baby clinics are a good example of this kind of disease prevention and health promotion. They start at the right time—with the infant and with the education of the parent.

For children and adolescents, the educational infrastructure already is in place. Matrices for education exist in schools, in peer groups—the Scouts, the 4-H Clubs, the Boys' Clubs, in church groups, in a great variety of gathering places where intelligent decision-making can be taught and practiced.

But there is a degree of foolishness and fruitlessness in each of us going off to do our own thing by way of health education. It is imperative that we work together within our communities. The greatest success nationwide will result from communities and states working together. And nations can only succeed by setting common goals and striving to reach them *together*. The infrastructure of the World Health Organization has proved its value. Smallpox would never have been made to disappear without worldwide cooperation. *Cooperation* is almost synonymous with *success*.

I do not mean that concerned individuals cannot begin at home and develop cooperative programs within the community. I do mean that communities should be persuaded to have coordinated efforts. States should work toward coordinated efforts.

You can persuade your teenagers to drive carefully, but they are not safe until strict community traffic laws are passed and enforced. They are not safe until stiff laws govern all highways, and all states

require strict enforcement of all laws for all people. Similar interaction is essential for successful health promotion related to any good-health inhibitor.

I have discussed problems in health education and some avenues we might take to educate for the maintenance of health. I would like to conclude on a note of hope.

Disease prevention and promotion of public health are already growing in importance in health sciences education. Health educators are increasingly aware of the need, both from an economic point of view and from the sure knowledge that prevention is always better than a cure. We are hearing new voices which tell us that our emphasis in health care may very well have been misplaced in recent years. Maybe our vast health care industry is too firmly based on the concept of illness when we might better emphasize wellness—the state of having, improving and keeping good health.

Investment in preventing illness and in promoting health is sound. It is an idea that merits our best thought. I personally am dedicated to the concept, and at the Texas Tech University Health Sciences Center I expect my own dedication and that of others to be translated into a growing curriculum focusing on wellness, health promotion, and disease prevention. I do not think our programs will be isolated or unique. Other health sciences centers will be following this trend.

Our ideas are not new. Ancient Chinese texts outlined ways of life to provide good health. The Greeks saw that the ideal man tempers the body to preserve the harmony of the soul.

Today's Americans are healthier than ever. Even better than that, Americans are showing an increasing concern for good health. I believe this concern is a broad one. Most Americans perceive, I think, that it is not enough to be concerned only about themselves individually or about only their own immediate families. We are civilized enough to want a healthy society.

Our combined concern can bode well for our future. After all, we live in a society that battled smallpox and won. We know how to prevent crippling polio and many childhood diseases. We can reduce the incidence of lung cancer and heart disease.

If we know how to do these things, we can learn better how to educate laymen to behave as they have not behaved.

Appenzeller, in his excellent discourse "What Makes Us Run," points to the present emphasis on physical activity for everyone. He refers to the prediction that a "few decades from now the situation

of athletics will resemble that of painting in the middle of the 17th century, of ballet before World War I, and piano music during the 1920s, and that through the training of the motor system and its influence on physical performance and behavior, sport is destined to show its powers by creating a 'third culture' if one accepts the humanities and natural sciences as the first and second."[19]

Whether or not that is true, we have made progress in our educational efforts regarding exercise. And Americans have become aroused to a need for disease prevention and health promotion. We have made progress in our educational efforts. I anticipate a speeding up of those efforts and, with that acceleration, greater progress in educating the laymen for the maintenance of good health.

FOOTNOTES

[1]"Education does not mean teaching people what they do not know. It means teaching them to behave as they do not behave. It is not teaching the youth the shapes of letters and the tricks of numbers, and leaving them to turn their arithmetic to roguery and their literature to lust. It means, on the contrary, training them into the perfect exercise and kingly continence of their bodies and souls. It is a painful, continual and difficult work to be done by kindness, by watching, by warning, by precept, and by praise, but above all—by example." John Ruskin, *Stones of Venice,* 1853.

[2]William B. Foege, "Prevention and World Health, the Next Two Decades," first Katherine Boucot Sturgis Lecture presented at the 26th annual meeting, American College of Preventive Medicine, November 4, 1979, New York, N. Y.

[3]John R. Evans et al., "Health Care in the Developing World: Problems of Scarcity and Choice," Shattuck Lecture presented at the Bicentennial meeting of the Massachusetts Medical Society, Boston, Mass., October 31, 1981. *The New England Journal of Medicine,* Vol. 305, No. 19, November 5, 1981, pp. 1117-1127.

[4]Foege, Sturgis Lecture.

[5]U.S. Department of Health and Human Services, December, 1981, report.

[6]*Ibid.*

[7]Evans et al., "Health Care in the Developing World," p. 1122.

[8]U.S. Department of Health, Education and Welfare, Public Health Service, "Healthy People," *The Surgeon General's Report on Health Promotion and Disease Prevention 1979* (Washington, D.C.: U.S. Government Printing Office, 1980), Chapter 11, p. 2.

[9]*Ibid.,* pp. 1-7.

[10]George Gerbner et al., "Health and Medicine on Television," *The New England Journal of Medicine,* Vol. 305, No. 15, October 8, 1981, pp. 901-904.

[11]"Healthy People," pp. 5-11.

[12]Gerbner et al., "Health and Medicine on Television," pp. 903-904.

[13]Otto Appenzeller, "What Makes Us Run?" *The New England Journal of Medicine,* Vol. 305, No. 10, September 3, 1981, p. 579.

[14]"Healthy People," pp. 9-17.

[15]*Ibid.,* pp. 10-15.

[16]*Ibid.,* pp. 10-4—10-5.

[17]Thomas J. Coates et al., "Heart Healthy Eating and Exercise: Introducing and Maintaining Changes in Health Behavior," *American Journal of Public Health,* Vol. 71, No. 1, January 1981, pp. 15-23.

[18]Evans et al., "Health Care in the Developing World," p. 1120.

[19]Appenzeller, "What Makes Us Run?" p. 579.

THE FUTURE OF PREVENTIVE MEDICINE

CHARLES C. SPRAGUE

While the title for this particular session is "Personal Responsibility for Personal Health," and Dr. Cavazos was to speak on the subject of "How Shall We Educate the Laymen Concerning the Maintenance of Health," I was not exactly sure what I should cover in my remarks. Perhaps I am taking too much liberty in my interpretation of my subject; but as I looked over the program, it appeared that there might be some important considerations regarding preventive medicine which may not be touched upon by others.

I would like to divide my remarks into two general categories. First, I would like to speak about the lifestyle of the individual and how that lifestyle impacts upon his or her health. Undoubtedly, there will be some overlap in my remarks and those provided by Dr. Cavazos. If there is appreciable redundancy, my apologies. The second category of my remarks will relate to what the medical profession itself can do over and above educating the public with respect to preventive medicine.

The alarming rate of increase in health care costs in the past fifteen years (from 6 percent of our gross national product to 9 percent) and the growing knowledge that these increased expenditures have done little to promote good health or prolong healthy life have created a growing concern on the part of the public. Clearly we need to place greater emphasis on prevention of disease whether it is by modification of lifestyle or through medical advances. Certainly there is much to be done in both areas.

There are three major risk categories in determining the health of an individual. The first are inherited biological risks. Heredity determines basic biological characteristics; and these may be of a kind where there is an increased risk for certain diseases such as heart disease, cancer or diabetes as well as genetic transmission of specific diseases such as hemophilia and sickle cell anemia.

The second category of risks is environmental. Often the onset of ill health can be linked to influences in physical, social, economic or even family environmental factors.

The third category is behavioral. Personal habits play critical roles in the development of many serious illnesses as well as injuries from violence and automobile accidents.

In most of the above, something can be done to minimize the adverse impact of such factors, but I shall not elaborate on this further for I am assuming that Dr. Cavazos will have covered this aspect of preventive medicine quite thoroughly in his remarks. If there are additional questions or topics, perhaps the discussion period will permit us to deal with them.

I would now like to move to the second area of prevention that I mentioned. First, what information can the medical profession offer that is presently available but which the public is not taking advantage of? Secondly, what are the possibilities of furthering the cause of preventive medicine by virtue of new discoveries.

My first plea in this regard would be that we recognize that *true* prevention of the major killers—cancer, heart attack and stroke—will only come from an investment in basic research. When one thinks of the enormous amount spent on high technology procedures and the priorities established by our federal government for the allocation of federal funds, I fear that we are not making the wisest possible investment of such funds. For example, the annual expenditures for coronary by-pass surgery exceed $2 billion; this is more than twice the annual budget for the National Institute of Health for Heart, Lung and Blood Diseases. The defense budget is several *hundred* times the Heart Institute budget. The savings that have been achieved by the control of poliomyelitis, diphtheria and tuberculosis alone are considerably greater than all the expenditures on basic biomedical research over the past forty years. For some reason the public at large and politicians in particular seem to have difficulty in recognizing this. At the same time, every successful industry places great value on and invests heavily in its research and development program.

Among preventive measures presently available, I would like to discuss one in particular where prodigious gains have been made over the past decade. Despite these gains and what the profession now can offer, the public is not taking advantage of this to the extent it should. I am referring to perinatal care in general and the prenatal diagnosis of genetic disorders in particular. A variety of techniques now make it possible to learn much about a fetus's genetic and metabolic state, chromosomal constitution (including gender) and bone structure and to do so earlier and earlier in the gestation period. Most of these

techniques yield such information at a time that makes selective abortion of the fetus legally possible. Time does not permit—nor am I adequately qualified—for us to discuss a variety of troubling moral, social and legal questions that must always be kept in mind for the exercise of responsible decision making in this regard. Perhaps Dr. Foster will address this matter in his presentation this afternoon.

I would like to emphasize at the outset that such prenatal genetic studies should be carried out in specialized centers by obstetricians and clinical geneticists who are thoroughly familiar with the procedures involved.

The first and most important recent development in such prenatal diagnosis is amniocentesis. In this procedure, a needle is inserted through the abdominal wall and uterus to obtain amniotic fluid and fetal cells contained within the amniotic fluid. Sonography is carried out before the needle is inserted in order to detect multiple pregnancies, to determine gestational age and to select the most appropriate site for insertion of the needle. Amniocentesis is indicated in pregnancies where there is an unusually high risk for chromosomal disorders, for detection of inborn errors of metabolism where it may be suspected, and a few specific malformations. It is important to realize that one cannot determine that a fetus is free of all birth defects by amniocentesis. Moreover, it is not possible to test any single amniotic fluid specimen for more than a few currently identified disorders. For this reason, only those tests which are apt to be abnormal are performed in each given instance. A chromosomal analysis is usually done routinely because one-half of one percent of all newborns have cytogenetic abnormalities. An estimation of the alpha-feto protein concentration is made since this test is very sensitive in the detection of neural tube defects such as spina bifida. Such neural tube defects occur once in every 1,000 live-born infants. Additional tests to detect specific biochemical defects are performed only in families which are known to carry the relevant mutant gene or genes.

Ultrasonic scanning (sonography) is another useful technique that has been used to diagnose a number of congenital abnormalities as well as to determine the presence of multiple fetuses and the location of placental attachments.

Radiography, either alone or following introduction of contrast material into the amniotic fluid, is also quite helpful in diagnosing anatomical abnormalities.

The most recent innovation in prenatal diagnosis has been the development of fetoscopy. This consists of inserting a small endoscope

(similar to a bronchoscope used to visualize the passages of the lung) transabdominally into the amniotic cavity. In addition to visualizing the fetus, it is now possible to collect samples of fetal blood through the fetoscope. Such blood samples have permitted prenatal diagnosis of blood disorders such as sickle cell anemia and hemophilia. The fetoscope also permits direct biopsy of fetal skin which can be used for fibroblast culture.

We had an experience at our own institution which illustrates how data obtained from amniocentesis can be used by the parents in judging whether or not they wish to have the mother carry the fetus to term or have an abortion. Two faculty members at the Health Sciences Center have elucidated the biological abnormality in a disease called familial hypercholesterolemia. If an individual has inherited a single abnormal gene from one parent and a normal counterpart gene from the second parent, then the disease is a relatively mild disorder with a moderate elevation of the serum cholesterol but often associated with coronary artery disease in midlife. If the individual receives one abnormal gene from each parent, there is evidence of a markedly elevated blood cholesterol level from birth. The individual almost always dies from a heart attack prior to the age of ten years. There was a couple living in Belgium whose first child had been so affected and died of coronary thrombosis at an early age. The wife became pregnant again. Her physician, who had heard of the work of Dr. Goldstein and Dr. Brown at our institution, informed the couple of the possibility of prenatal diagnosis. After consultation with Dr. Brown and Dr. Goldstein, the Belgium physician performed an amniocentesis and had the amniotic fluid sample flown to Dallas where the cells in the fluid were cultured and tested for the defect present in familial hypercholesterolemia. The results indicated that the fetus had in fact received an abnormal gene from each parent and it was predicted that this child, if the pregnancy were allowed to go to term, would have a similar fate as the first child. The mother decided on an abortion, and even at that early stage of development the fetus had not only a serum cholesterol level some six times normal, but the arteries had already developed atherosclerotic changes associated with advanced coronary artery disease.

You will note that I have not yet addressed the subject of genetic engineering and the potential of such technology to correct certain genetically transmitted disorders. Suffice it to say that the field of recombinant DNA research (genetic engineering) is booming. As might be expected, claims of some individuals as to what the future

may hold are probably much too optimistic. Undoubtedly, however, we shall see significant advances in this field over the next decade.

The reason I have chosen to speak at such length on the health of the newborn is the result of my exposure to the research being carried out in the Cecil and Ida Green Center for Reproductive Biology Sciences at our institution. The quality of life of a newborn is a major determinant of the quality of the later life of that individual, and we should strive to do everything possible to ensure the highest possible quality of life of every newborn. Research is now being directed toward minimizing the frequency of premature births with a corresponding reduction in the increased incidence of morbidity and mortality associated with prematurity. The recognition of the biochemical and biological process by which lung maturation in the fetus occurs offers the possibility of eradicating hyaline membrane disease in the newborn with its high mortality rate and increased incidence of mental retardation. Thus, exciting possibilities lie on the immediate horizon.

I am sure you are all aware of the continuing progress that has been made in the area of immunization for additional infectious diseases such as measles and hepatitis, and I shall not elaborate on that subject except to say that it is anticipated that this progress will continue.

In addition to carrying out basic research that is the most cost-effective way of preventing disease, physicians in practice are not emphasizing preventive medicine as much as they might.

Perhaps the most comprehensive survey of public opinion with regard to preventive health issues was that commissioned by The Pacific Mutual Life Insurance Company and conducted by Louis Harris & Associates in 1978. This survey was concerned with what could be done—whether by individuals themselves, by physicians, by employers, by labor, by the health insurance industry or by local, state or national governmental bodies—to reduce the incidence of disease and promote healthful life habits in the population. In this study, 57 percent of the persons surveyed thought that they would be greatly helped in achieving a healthy diet if they received nutritional advice from their physician. Less than one in ten of those who had been successful in losing weight attributed this to advice of their physician and only 16 percent of those who had gone on a diet of any sort said that they were prompted to do so by their physician. Only 17 percent of those involved in regular exercise first became involved because of the recommendation of their doctor. And only

25 percent of those who believed they should take more exercise had ever discussed possible benefits or risks of exercise with their doctor. The majority of smokers believe that medical advice would be an effective way of helping them to stop smoking, yet only 8 percent of those who had succeeded in stopping smoking did so on the recommendation of their physician. Parenthetically, I might mention that 37 million Americans have stopped smoking, but at the same time cigarette sales have continued to increase. I was unable to find any accurate data on the number of new smokers each year. It is known, however, that with the marked increase in smoking among females over the past twenty to thirty years that lung cancer among women is rising rapidly and soon may exceed the frequency of breast cancer.

Clearly, both the individual and the physician are doing far less than they should in the way of preventive medicine. I would like to conclude my remarks by showing one slide which says a great deal about what an individual or a society can do in the way of preventive medicine. It indicates the incidence of deaths from coronary artery disease in the United States, Australia, Great Britain, Sweden and Japan. You will note that in 1968 the United States and Australia had the highest frequency among these nations, but by 1977 each of these two countries had showed a decrease of 25 percent. The death rate in Great Britain, Sweden and Japan remained essentially unchanged. The Japanese owe their low mortality rate, not to their genes, but rather to their way of life. When the Japanese move to the United States they rather quickly acquire American rates. These patterns indicate that coronary artery disease is largely, although not entirely, preventable.

It is regrettable that neither the public nor the medical profession is committed to an all-out effort in the area of preventive medicine. The number of lives that could be saved, the improved quality of life that would result, and the billions of dollars that would be saved are staggering. It is a sad commentary on our society that we are so apathetic regarding such an important aspect of our lives.

SESSION III

Chairman of the session entitled "The Ethics of Health Care: Policing the Health Professions" was Thomas H. Law. Speakers were Truman G. Blocker, Jr., president emeritus of The University of Texas Medical Branch at Galveston; Charles O. Galvin, dean of the Law School at Southern Methodist University; and Daniel W. Foster, professor of internal medicine at The University of Texas Health Science Center at Dallas.

THE ETHICS OF HEALTH CARE: POLICING THE HEALTH PROFESSIONS

T. G. BLOCKER, JR.

The majority of medical schools in the United States include in their commencement exercises the administration of the Hippocratic Oath, which dates from the fourth century B.C. Most doctors ascribe the oath to Hippocrates himself rather than to his colleagues and followers. Hippocrates was born in 460 B.C. on the Greek island of Cos off the coast of Asia Minor. His teachings in clinical medicine were conducted (so it is reported) in the shade of an enormous plane tree (or sycamore)—46 feet in diameter—which has been described by Dr. William Gibson as "a high-domed mass of greenery" in summer, covering most of a city square, and in winter resembling "the vascular system of the kidney." Modern-day medical pilgrims are frequent visitors to the island. They are not so much interested in the history of medicine as sentimental over the Hippocratic Oath which recalls their initial certification as doctors and their dedication to the highest principles of the profession on graduation from medical school.

Egyptian, Hindu, Chinese and Babylonian codes of ethics preceded the Hippocratic Oath, with similar charges to neophyte practitioners, and rules of conduct were formulated for Hebrew physicians and for graduates of Japanese medical schools in the seventh and eighth centuries A.D. At about this same time a medical center evolved at Salerno on the coast of Italy. It followed Hippocratic precepts; and with establishment of a formal five-year course here about 1100 A.D., graduates of this school (titled Doctors, for the

first time) were required to promise "to uphold the honor of the school, to attend the poor without fee, and not to administer any poisonous drug to their patients."

In 1794 an English physician, Thomas Percival of Manchester, formulated and published a code of behavior for doctors entitled *Medical Ethics,* which was a guide to practice, fees and professional etiquette. His rules were adopted by the American Medical Association when it was established in 1847 and by the Texas Medical Association in 1853. The Hippocratic Oath was also approved by the AMA in its traditional form in which physicians swear upon Apollo and all the other gods and goddesses of ancient Greece.

The World Medical Association in 1948 approved a modernized revision of the Hippocratic Oath; this takes into account the Nüremberg Code of Ethics in Medical Research, which served as a guide during the trials of Nazi war criminals, condemning unwarranted and inhuman experimentation upon clinical subjects. The Declaration of Geneva reads as follows:

> I solemnly pledge myself to consecrate my life to the service of humanity.
>
> I will give to my teachers the respect and gratitude which is their due.
>
> I will practice my profession with conscience and dignity.
>
> The health of my patient will be my first consideration.
>
> I will respect the secrets which are confided to me.
>
> I will maintain, by all means in my power, the honor and the noble traditions of the medical profession.
>
> My colleagues will be my brothers.
>
> I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
>
> I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
>
> I make these promises solemnly, freely and upon my honor.

It is interesting that in neither version of the Oath does the physician agree to relieve his patients of pain and suffering. The original oath opposes administration of deadly drugs, prescribing abortion remedies and use of the knife, "not even on sufferers from stone," withdrawing "in favor of such men as are engaged in this work." Thus it may be seen that even in early days the specialists respected each other.

Each year at The University of Texas Medical Branch senior students decide by vote in advance the version of the Hippocratic Oath which they prefer as they select the faculty member who will administer the oath to them. Their choice is usually the traditional archaic one, which allows for certain mental reservations.

Since the early 1900s a number of revisions of the principles of medical ethics have been made by the American Medical Association. The most recent document, prepared by the Judicial Council of the AMA, has been published only this year. The 30-page document provides for investigation of complaints of unethical conduct "of greater than local concern" and the mechanism for disposal of charges: acquittal, admonishment or censure, suspension from AMA membership, or expulsion.

The physician, of course, may be subject to prosecution for violations of any civil or criminal laws; acquittal by the courts, however, does not exempt him from disciplinary action on the part of the appropriate medical boards or committees.

Complaints which require judicial action on the part of the AMA are ordinarily referred from local county medical societies after investigation by their grievance committees. Such complaints may arise from patients and from the general public as well as from medical and paramedical personnel. Most hospital staff organizations also include a Board of Censors, usually the Executive Committee acting as a grievance committee. Its members investigate violations of accepted surgical and medical procedures, dereliction of duties, patient neglect, improper conduct, etc. Minor complaints may be processed by the hospital administration with appeal to governing boards as requested. Physicians are subject to censure through their hospital staff affiliations and as a result of action by state examining boards even though they do not hold membership in county medical societies and AMA. As a matter of fact, however, most hospital staff appointments require that applicants be members in good standing of their local societies, which practice gives those organizations considerable power.

The Medical Practice Act of the State of Texas—extended and revised by special session of the Legislature last August—provides for a 15-member Board of Medical Examiners (including 3 nonphysicians) charged with issuing licenses on the basis of submitted credentials of training and either examinations or by reciprocal agreement with certain other states. The Board also has disciplinary powers over members of the profession who commit unethical or

illegal acts, who are unable to practice medicine with reasonable skill and safety (that is, as the result of medical or physical disabilities), who employ disbarred individuals, or even who "flagrantly" overcharge or overtreat a patient. Much of the Board's investigative activity is concerned with misuse of alcohol and narcotic drugs and other controlled substances, whether by prescription for patients or for self-administration. By law the Board of Medical Examiners is charged with assessing penalties, which range from a Class A misdemeanor to a third-degree felony, for persons practicing medicine without a license. These are chiefly of two categories: (1) persons who make false claims to be physicians or surgeons and diagnose, treat or offer to treat any disease or disorder, mental or physical, or any deformity or injury or to effect cures thereof or (2) persons who charge money or other compensation for diagnosis and/or treatment. The board does not consider the following persons to be illegal practitioners of medicine: ministers (unless they offer medications); licensed health professionals, who may carry out all procedures consistent with their education and training within the limitations of their licenses; contract surgeons with the military; medical students; advisers on nutrition; and persons offering emergency assistance to the sick and injured.

An occasional case of a physician imposter, practicing either under his own name or after assuming false identity and credentials, is brought to the attention of the State Board of Medical Examiners. Just prior to World War II one such fraudulent doctor on our faculty at the Medical Branch in Galveston established himself as a British doctor (actually this individual had been killed in the Spanish Civil War). The imposter had had one or two years in medical school in the Midwest and had decided ideas about changing the curriculum. Some of the faculty were suspicious of his glib discussions of papers believed to have been published by him, and the students tricked him by having him describe the retina of a patient who turned out to have a glass eye. But he was officially exposed only when he applied for an Army commission. Another recent imposter in an East Texas town was so beloved by his patients that they begged for him to be allowed to keep on practicing medicine without a license.

Several years ago there was an exposé on the television show "Sixty Minutes" of persons acquiring fake medical diplomas or stealing blanks prior to filling in the name of the prospective recipient. I was quite surprised to recognize my signature (or a reasonable facsimile) on a Master's diploma in one of the basic sciences.

Persons employed in a doctor's office or in a hospital environment may not initiate therapy but must be working under a physician's specific orders, whether or not there is direct supervision. Optometrists must have local physician referral prior to employing diagnostic medications, and they are accountable by law for any ill effects which may result (this provision of the Medical Practice Act has been bitterly contested). Otherwise, a physician must assume medical and legal responsibility for persons to whom he delegates responsibility. A nurse or an aide may not diagnose, treat, fail to follow orders or alter dosages of drugs, even out of humanitarian or other considerations, such as religious or personal convictions of what is proper therapy. The AMA principles of ethics spell out, however, that the physician does not have the right, either, to make the final decision to "exert maximal efforts" to prolong life in the case of defective newborn infants. This right belongs to the parents after consultation with the attending doctor, and he is, therefore, considered to be exempt by his peers from the charge of mercy killing by neglect, although such cases occasionally reach the criminal courts. This rule of ethics is in conflict with some religious sects, as is the right to perform legal abortions which are consistent with what is termed "good medical practice." In the case of terminally ill patients not in the deformed newborn category, the physician is obligated to consult with family members or other responsible persons before starting or stopping potentially life-prolonging therapy unless a diagnosis of irreversible coma can be confirmed. The criterion of flat brain waves is not specifically mentioned in the code, and the Medical Practice Act does not contain quality of life provisions as such.

The State Board of Medical Examiners and the Texas Medical Association have been powerful forces in raising the standards of medical education and practice in ridding the state of charlatans, faith-healers, patent medicine men, etc., whose activities flourished in the early part of this century. They have also sponsored legislation affecting sanitation, contagious disease control, food and drug standards, and other matters affecting public health and hygiene.

With growth of specialization in medicine, especially in the years since World War II, more than 20 examining specialty boards exist for examination and certification of candidates, in addition to the powerful American College of Surgeons, the American College of Physicians and other prestigious organizations. These societies have, however, few provisions for censure of unethical practitioners. Much

more effective are those "watchdogs" which set standards for hospital accreditation, a prerequisite for many third-party payments to physicians and for Medicare approval. Thus, although doctors are rarely policed as individuals, their income may be directly curtailed if inspections reveal substandard physical facilities or deficiencies in records, documentation and review of surgical and medical cases, or failure to provide adequate in-service teaching programs.

The Joint Commission on the Accreditation of Hospitals, founded in 1951, is composed of representatives from the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. Upon request for a survey and upon payment of a fee based upon the institution's bed capacity, a team of three to seven persons is sent to judge the level of medical care and to inspect the physical plant. The team component always contains a physician, an administrator and a nurse; sometimes a dietician is included, as well. As a rule, the local Health Department is invited to participate and the committee insists upon strict adherence to fire prevention codes. Record room charts are inspected. Conferences are held with departmental chairmen. Audits are conducted to confirm that peer review has been carried out. And reports are received from at least four hospital committees which must meet monthly to comply with the Joint Commission rules. These are as follows: A Grievance Committee, or Board of Censors (as mentioned previously); a Tissue Committee, which reviews controversial cases, inquires of individual surgeons their justification for certain types of procedures and reviews other cases, ordinarily at random; a Medical Audit Committee, which reviews non-surgical cases; and a Morbidity Committee, which reviews various medical complications and in post-mortem cases.

Full accreditation by the Joint Commission means two-year approval. Conditional accreditation (with suggestions for improvement) is for one year only. When there is no approval or in hospitals which are not surveyed, an obligatory Medicare Survey—much more stringent than the Joint Commission inspection—is carried out. Usually Medicare accepts Joint Commission findings.

Another important factor in policing physicians and surgeons is the fear of medico-legal suits and the enormous cost of malpractice insurance (highest for plastic- and neurosurgery in most states, where it may cost $40,000 annually or even be unobtainable if the doctor has been sued on several occasions). Most suits are the result of

poor interpersonal relationships and the failure of physicians to realize that their patients not only have unrealistic expectations of the results of treatment, especially in the case of elective surgery, but often do not realize what was done and the risks involved.

A recent AMA survey reports that the general public is satisfied with the quality of health care, but both patients and physicians are greatly concerned with rising costs. The practice of charging according to ability to pay has almost disappeared. More and more hospitals have established fee schedules, and most physicians' and surgeons' fees are becoming standardized, according to the locality, partly through peer pressure and partly as the result of insurance company policies of payment, which serve (along with possible Medical Practice Act censure) to curb surcharges to a large extent. The AMA Judicial Council lists six guidelines for determining the reasonableness of a fee. These include, among others, the difficulty of the service performed, the time and skill, the results obtained, and the reputation and ability of the physician. Most doctors are unable, however, to judge the quality level of another doctor's practice, unless it is extremely good or extremely bad. Hospital Committee reviews will show a pattern, but ordinarily judgment of professional ability is largely on a subjective level unless one has "inside" information on surgical procedures from a trusted anesthesiologist.

As medical practice becomes more complex, new ethical problems arise. Formerly doctors squabbled about fee-splitting (that is, accepting remuneration without performing a service for the patient); advertising (now considered ethical unless one guarantees results or makes fraudulent claims); and the etiquette of handling consultations. Physicians (and the public, as well) must now be concerned with such social policy issues as indications for abortions, artificial insemination and *in vitro* fertilization; fetal research; genetic engineering; organ transplantation; discontinuance of life support measures; protection of confidentiality of doctor-patient communications, especially with information stored as computerized data; access to new drugs; and other types of human experimentation. One of my former residents, now a prominent surgeon, is a world authority on the treatment of snake-bite. In furtherance of his research he persuaded one of his trainees to allow himself to be bitten by a rattlesnake so that a teaching film might be made of the course of therapy. "Cliff," I said, rather appalled, for most of us are morbidly afraid

of snakes, "How did you ever get that project okayed by the Committee on Human Experimentation?" "Chief," he said, ducking his head, "I'm chairman."

As the world of medicine becomes more and more sophisticated, and as I grow older, I recall more and more some of the sayings of a wise colleague of mine in the Texas Surgical Society—Dr. W. B. Russ of San Antonio, who was already 60 when I first met him in the 1930s and had become what I have described as the self-appointed conscience of Texas physicians. He often quoted Galen as saying that doctors are prone to treat the disease that *has* the patient rather than the patient that *has* the disease. Dr. Russ wrote many essays with the theme "Let the Old Man Die in Peace" and bemoaned the fact that even when a patient who has all the infirmities of old age is comatose and approaching a certain—and what should be a *peaceful*—death, he becomes surrounded in a hospital by doctors, nurses and technicians desperately trying to *wake him up,* assisted by oxygen, all the modern drugs and stimulants, needles and plastic tubes. Of course, today, there would also be the pump and prolonged discussion as to who should make the decision to "pull the plug."

In times of moral dilemmas the wishes of the patient, while in possession of his faculties, and of his family, who will soon *own* the body of the deceased—by law—must guide the physician, who is torn between his conscience, which bids him to relieve suffering, and his oath to remember the sacredness of human life.

Fashions change in medical ethics as in other matters, and Sir William Osler has written: "Each age has its own spirit and ideas, just as it has its own manners. . . ." Many doctors, moreover, neglect to consider the contribution of the patient himself—physical, mental and spiritual—which points the path toward death or recovery. Edward Kentish wrote in 1797 of the vanity of the physician:

> It falls to the lot of few men to appreciate properly the effect of various modes of treatment in a particular disease; for if the patient recovers, whatever was the treatment, whether good or bad; we flatter ourselves it was the effect of our superior merit in conducting the disease; but future experience will convince us that the recovery, of which we so vainly boasted, was a victory of nature over the malpractice of art. . . .

MEDICAL ETHICS AND THE LAW

CHARLES O. GALVIN

In the course of our discussion today there have been several references to the burden of regulation and its costs. In this connection and in keeping with our concerns for life and health and the dilemmas of death and dying, my favorite passage is from a recent issue of the *Federal Register,* Vol. 46, No. 170, for September 2, 1981. It is a proposed amendment to section 227.72 of the regulations under The Endangered Species Act of 1973 and is promulgated by the Acting Executive Director of the National Marine Fisheries Service. The amendment is to sub-section (e), paragraph (1), subparagraph (i), Clauses (A) and (B) and reads as follows:

> (A) Sea turtles that are dead or actively moving must be released over the stern of the boat. In addition, they must be released only when trawls are not in use, when the engine gears are in neutral position, and in areas where they are unlikely to be recaptured or injured by vessels.
>
> (B) Resuscitation must be attempted on sea turtles that are comatose or inactive but not dead by: (1) placing the turtle on its back (carapace) and pumping its breastplate (plastron) with hand or foot, or (2) placing the turtle on its breastplate (plastron) and elevating its hindquarters several inches for a period of one up to twenty-four hours. The amount of elevation depends on the size of the turtle; greater elevations are needed for larger turtles.
>
> Sea turtles being resuscitated must be shaded and kept wet or moist. Those that revive and become active must be released over the stern of the boat only when trawls are not in use, when the engine gears are in neutral position, and in areas where they are unlikely to be recaptured or injured by vessels. Similarly, sea turtles that fail to move within several hours (up to twenty-four if possible) must be returned to the water in the same manner.

Appropriate references are made to the Regulatory Flexibility Act, the Paperwork Reduction Act, the Administrative Procedures Act, and Executive Order 12,291. The usual forms are required to be filed reflecting the numbers of sea turtles resuscitated with the usual penalties for failure to file.

Those who are bestirred by the seriousness of the problem may make comments to the Director of the Northwest Region of the National Marine Fisheries Service in Seattle, and so regulation goes on and on.

When Bryce Jordan asked me to speak on this program, I responded, not being overendowed with modesty: "Of course, just tell me where and when and I'll speak on any subject from astrophysics to recipes for mustard greens and cornbread." When I did receive the program, however, I thought Bryce was carrying the joke a bit far, for there I am sandwiched in between two M.D.'s with the assignment of the subject of medical ethics and the law. I have no doubt that it would easily be the consensus of the physicians present that for a lawyer to lecture on medical ethics and the law is somewhat like asking the fox to lecture the farmer on security measures for the henhouse. Moreover, I can just feel the burning desire of the doctors to speak on the obverse assignment: lawyers ethics and medicine. As one of my good doctor friends said of a particular lawyer: "He couldn't have any ethics, for if he did, why did he sue me?"

Our two professions share much in common. We deal with our fellow human beings most often in circumstances of great stress and anxiety. In the philosopher's terms both of us are deeply involved with the experiences of the human condition and the human predicament. In recent years both professions have been blessed with a flow of extraordinarily competent students. One need only look at the academic profile of any of our recent entering classes in the law schools or medical schools to be impressed with the backgrounds, the achievements, the aptitude test scores of those admitted to the programs of our respective curricula. Older hands at the law, as I am sure is the case with older hands at medicine, marvel in admiration at the intellectual acuity and mental incisiveness of the young men and women now graduating from our professional schools.

The same older hands find, however, that these bright, alert, technically competent young men and women are often incredibly insensitive to the broader concerns of the society, the true meaning of profession, the importance of a large measure of selflessness, and commitment to the community of which they are a part. Therein lies a problem in ethics for us both. If we lose our sense of pride in performing the duties of our respective callings at the highest possible standards, then we could become mere mechanics turning out our work in assembly line fashion and most certainly lose our

enthusiasm for disciplining those who fail to comport with and conform to standards of excellence.

The legal profession is at the present time struggling with one of the most controversial matters ever placed before it—a proposed new Code of Professional Responsibility. This proposed code would impose upon the lawyer a duty to the processes of justice which some critics say could override the duty to the client. Thus, the new rules could be viewed as urging the pursuit of pure truth—truth and full disclosure—as a value in and of itself that may be even higher than the value of the zealous representation of the client's cause.

The proposed rules attempt to deal more strictly with problems of the confidential relationship between the lawyer and client. That confidential relationship as in the case of medicine is so important, on the one hand, for the protection of the lawyer and client; and yet, on the other hand, that same confidentiality cannot be used as a screen or shield which would permit the lawyer to assist the client in a course of conduct that is fraudulent or criminal. The cases in this area are never black and white but exist in all shades of gray, and therein lie the nagging dilemmas with which lawyers must constantly deal. Proponents of the proposed new code assert that it is merely a codification and clarification of existing law. Opponents say that it goes far beyond and imposes burdens on the profession not heretofore recognized. The debate will continue at upcoming meetings of the American Bar Association. Should it be accepted, it would still be up to the several states to adopt, modify, or discard such rules.

I mention these ongoing current concerns in the legal profession because of some very recent and parallel developments in our own state affecting medicine.

In the case of the medical profession the enactment of the new comprehensive Medical Practice Act (V.A.C.S. Tex. Art. 4495b), which became effective last August 5, is certainly a significant development in the history of medicine in Texas as it concerns the regulation and disciplining of the profession. To be sure, we have had a multiplicity of statutes dealing generally with the practice of medicine and the practice of other health delivery and health ministering services. The new act, however, is an attempt to update and codify in one place a massive body of rapidly developing law.

In 37 pages of an extensive and detailed statutory formulation that is easily worth a semester seminar in medical school, the Legislature has defined unlawful and prohibited practices which are Class

A misdemeanors and has set out 21 grounds for refusal to license or relicense, included among which are descriptions of what is deemed to be unprofessional or dishonorable conduct.

For the physician and his counsel the statute is a veritable mine field of danger. It carries forward previously proscribed conduct and enlarges thereon: prescribing or administering a drug or treatment that is non-therapeutic or non-therapeutic in the manner the drug or treatment is administered or prescribed; prescribing, administering, or dispensing in a manner not consistent with public health or welfare dangerous drugs; persistently and flagrantly overcharging or overtreating patients; failing to supervise adequately the activities of those acting under the supervision of the physician; professional failure to practice medicine in an acceptable manner, consistent with public health and welfare; and so on. There are also definitive new rules relating to privileged communications between the physician and patient with some quite particularized exceptions.

As I read through these legal rules affecting medicine, I am more than ever convinced that our two professions need to collaborate and cooperate with one another in matters of standards, conformity to standards, and other ethical and disciplinary concerns. In the past we have held each other in high esteem. Of course, it may be said in passing that it's always been true that physicians have thought of lawyers as the worst patients because they constantly heckle the doctor with cross-examination, and lawyers find doctors exasperating as clients because doctors often want to play lawyer. But never mind this. Historically, we have always regarded each other with mutual respect.

When I was coming through law school, the reported cases involving medical malpractice or legal malpractice were extremely rare. I am sure that medical and legal malpractice did in fact take place, but the number of instances in which representatives of either profession were challenged were at a minimum. You didn't sue your doctor; you didn't sue your lawyer, just as you didn't sue your teacher, your rabbi, your priest, or your pastor. You just didn't. Many practicing physicians and practicing lawyers did not even carry malpractice insurance because the risks were so slight. But then began the gradual evolution of the legal doctrines which are still developing at this very hour.

If a practicing physician in Plainview, Texas, performed a medical procedure which resulted in injury to his patient, the rule formerly was that the patient could recover damages from him if the doctor

failed to adhere to those standards, those norms of procedures, generally prevailing in that locality. Then, as specialization and its discoveries and improved technology became more available, the practicing physician in Plainview, Texas, could be held to those standards of the specialist in that particular procedure in that locality. Thus, the simple question was: what would the obstetrician, the pediatrician, the ophthalmologist, or the orthopedic surgeon have done in this locality in the same or similar circumstances? Progressively we have moved to even higher standards so that the competence of the practicing physician in Plainview, Texas, with respect to a particular treatment or procedure is tested against those treatments or procedures as they would be applied in the best medical centers in the land. In other words, the profession is put to a legal standard which requires not just an *aspiration* to deliver the best in medicine that is obtainable but in fact *is* the best in medicine obtainable. In this way the public is more nearly assured of a uniformity of excellence in professional services in the health care area throughout the country. The California Supreme Court states:

> We must note, finally, that the integrated and specialized society of today, structured upon mutual dependency, cannot rigidly narrow the concept of the public interest. From the observance of simple standards of due care of the driving of a car to the performance of the high standards of hospital practice, the individual citizen must be completely dependent upon the responsibility of others. The fabric of this pattern is so closely woven that the snarling of a single thread affects the whole. We cannot lightly accept a sought immunity from careless failure to provide the hospital service upon which many must depend. Even if the hospital's doors are open only to those in a specialized category, the hospital cannot claim isolated immunity in the interdependent community of our time. It, too, is part of the social fabric, and prearranged exculpation from its negligence must partly rend the pattern and necessarily affect the public interest. *Tunkl* v. *Regents of University of California,* 383 P. 2d 441 (Cal. 1963)

The Texas courts have responded similarly to standards for physicians in *Snow* v. *Bond,* 438 S.W. 2d 549 (Texas 1969) and *Hood* v. *Phillips,* 554 S.W. 2d 160 (Texas 1977). Moreover, the cases have set a high standard not only for the physician but for those under his supervision. This is the so-called "captain of the ship" doctrine which is echoed in the new Texas Medical Practice Act.

In the area of research all of us agree with the need for maximum medical experimentation in order to discover those new processes and procedures which will defend health and life; yet we are keenly aware of the sticky business of undertaking non-therapeutic procedures without the clearest kind of informed consent. What constitutes informed consent is a devilishly difficult question to resolve with any kind of clear specificity.

What can we do to resolve these ethical dilemmas for the practicing physician and the teaching and research physician. Medical care and medical research must be gotten on with efficiently, effectively, and economically. It cannot be slipshod and done by half measures. Yet we cannot subject the physician to harrassment and deterrence in doing his work.

There are representatives of our two professions who could deal with the problems of medical ethics and the law. Issues such as arbitration, procedures of peer review committees, limits on the use by lawyers of contingent fee arrangements, better articulation of standards for various medical procedures so that one physician is not overly cautious and another not cautious enough, review and dissemination of protocols for research, critical evaluation of insurance rate-making for different forms of medical insurance—all are areas of common concern. We hear so much about the shocking escalation of medical costs and a crisis in confidence about health care delivery. More than ever we need to work together toward the development of institutional arrangements for the solution of these problems.

Dr. Engelhardt challenged us last night to think critically about the allocation of society's resources to health care. Certainly, costly and protracted litigation and sometimes senseless squabbling over questions of duty and fault deflect the resources of time and energy of our best professional people from those important matters which directly relate to health delivery services.

Dr. Engelhardt also challenged us in a far more fundamental way concerning changing values and new technology. No issue in our national life today is more emotionally charged than the issue of abortion. The law affords the pregnant woman a discretion to have an abortion in the first trimester; in the second trimester she and her attending physician may make the decision; and in the third trimester the state may regulate abortion through its criminal and civil statutes. Certainly medical technology offers an easy, safe procedure for abortion.

Yet the fact that the law permits abortion and the fact that the medical procedure is easy and safe do not inescapably lead to the conclusion that the decision to abort is ethically defensible or morally justified. These are tough, sensitive and delicate questions requiring the best of professional hard thought, objective and dispassionate discussion together with other professionals in the ethical sciences, bioethics, and moral theology.

Just as law and medicine have worked together in the past in developing statutory rules for a more precise definition of death and rules for so-called living wills which have been adopted in many states, so we must work together to define the beginning of life, or more accurately, the beginning of personhood, at which time all the constitutional and statutory protections should be available to the individual yet unborn.

Just a word about the way most of us attack our problems. It has been my observation that from the time of the first day in law school we engulf our students in a world of controversy. Lawyers by the very nature of their business are adversaries, contentious, contesting, critical, argumentative, disputatious—in short, hard to get along with.

Medicine, on the other hand, teaches cooperation and collaboration, greater and more efficient use of support systems. The student doctor is taught early on how to palpate the patient, how to use the stethoscope, and how to work medical procedures. He is carefully led through the processes; he learns to work with his fellow professionals in a consultative and cooperative way.

The student lawyer is made to fend for himself, to swim against the stream, to be critical of opinions expressed by others no matter how experienced. For in legal education we believe this to be the best way to prepare the new lawyer for the plunge into the deep and icy waters of the adversary legal system.

These differences of approach indicate how necessary it is to structure joint committees to hammer out the institutional arrangements which will permit medicine to go forward in practice and research for the best interests of the public without the fear of harrassment and hassling that lies latent particularly in the extensive provisions of the new Medical Practice Act.

It has been my pleasure over many years of association with the Law School at Southern Methodist University as dean and professor to watch the developing interdisciplinary cooperation between our faculty and those at the Health Science Center. We have offered

seminars together, have done projects together, and continue to explore ways for further interlacing of our professional concerns. This is being done throughout the country between university law schools and university medical schools and should encourage members of both professions for the future to work even more closely together.

The tasks for our two professions will not be easy, but greater collaboration between us should be an important factor in resolving those difficulties that lie ahead.

SOME MORAL DILEMMAS IN HEALTH CARE—THE INTERACTION BETWEEN RELIGION AND MEDICINE*

DANIEL W. FOSTER

The breadth of moral issues facing medicine itself and the larger biomedical community is impressive. These issues are both societal and individual. Most attention has focused on the larger problems such as:

Defining life and death and deciding who is to control them.
Preparing rules for human research and informed consent.
Weighing risk-benefits of recombinant DNA techniques.
Dealing with the economics of medical care.
Solving the problems of world hunger and malnutrition.
Addressing the issue of population control and the related subject (in the West) of abortion.

In the few minutes allotted to me this afternoon, I do not plan to discuss these problems or to address, in overview, the moral dilemmas mentioned in my title on the program. The primary reason is that I do not feel qualified. I told Bryce Jordan that I was not trained in ethics and in consequence felt uneasy appearing in this forum. After all, what I am is an academic physician. I do research and I teach and I take care of sick people, but I don't usually write or talk on ethical and moral problems in medicine. He relieved my mind somewhat by indicating that I might focus on the practical arena wherein the individual physician interacts with a sick human being. In that context I want to think with you about a specific problem that is not often considered, the relationship between religion and medicine. And from the multitudes of problems flowing from their interactions I want to concentrate on two: the situation where the patient has strong religious beliefs not shared by the physician and the reverse

*An expanded version of this paper will appear as a chapter entitled "Religion and Medicine—the Physician's Perspective" in a book entitled *Health/Medicine and the Faith Traditions,* Martin E. Marty and Kenneth L. Vaux, editors, scheduled for publication in 1982 by Fortress Press in Philadelphia.

scenario where the physician is religiously motivated and the patient is not.

I think it apparent that religion cannot be ignored by physicians for two reasons. In the first place, religious beliefs are widely held in the United States and influence behavior even when the person is not sick. Secondly, and perhaps more importantly, when serious illness comes (and by that I mean illness which threatens life or leads to long-term disability), the experience induces a series of questions which are, in the most basic sense, religious. Let me expand on these two points briefly. It is well known that a majority of the American population specifically believes in God with a significant proportion actively participating in formal religious practice.

What is perhaps not as well known is that piety may actually be increasing. "Middletown" USA is a midwestern community whose religious beliefs were studied in depth at two intervals half a century apart. In 1924 only a quarter of married couples in this community regularly attended church, but in 1978 the figure had increased to half. In the twenties over one-half of the population never formally worshipped, but by the seventies only one-sixth reported that they never attended services. In 1924 only one of a hundred families tithed while in 1978 almost a third of active church members did so. While these findings apply specifically only to one community in middle America, other surveys indicate similar trends in the broader society.

Even if a person is not formally religious before illness comes, it is almost inevitable that serious, that is religious, questions arise with the threat of death. Most people, in their daily lives, spend relatively little time contemplating philosophical matters and certainly not life and death. Ordinarily we expect to live for a good period of time (even as we age) and, therefore, utilize our days for work and pleasure rather than for a consideration of meaning. Even when we hear of tragedy, we assume that it is something that happens to someone else and not ourselves. We may feel sympathy or shock, but not risk: others die, but we live. But when the ordinariness of life is disrupted by illness, there is an abrupt reorientation of questions, priorities and interests. The degree to which this reorientation occurs usually correlates with the seriousness of the illness or its perceived seriousness: one is not likely to ponder fate in response to a cold, but may well do so when faced with a cancer (or fear that one might have a cancer). Three categories of questions usually arise. The first questions are informational; i.e., What's wrong with me? How does

the disease manifest itself? Is there treatment? How long do I have to live? If the informational questions indicate serious illness, second phase questions begin and these are behavioral in nature. The words and thoughts behind them vary (and sometimes they are not expressed), but the tone is unmistakable. Can I go through with what I have to go through? Do I have courage? Will I be able to finish with dignity? Third phase questions are fundamentally religious. Why did this happen to me? What can I learn about life and about myself from this experience? For what may I hope? I do not plan to discuss these issues further. My only purpose is to indicate that in medicine one cannot ignore religion if one wishes to deal with the patient as a human being rather than simply to treat his or her disease.

Against this background I want to consider first the problems that can occur when a patient or the patient's family hold religious beliefs not shared by the health care team especially if they are considered to be irrational or a barrier to delivery of proper care. An excellent example is the case reported by Redlener and Scott from the University of Miami.

> A nine-month-old child was admitted to a teaching hospital of the University of Miami with a history of lethargy and convulsions of two days duration. Bacterial meningitis was suspected and subsequently confirmed. Because there was evidence of extensive central nervous system injury an arteriogram was requested by the physicians to rule out the presence of pressure-producing accumulation of fluid beneath the covering membranes of the brain. The family refused to allow the test on religious grounds, initiating a conflict with the hospital and its personnel that lasted for more than three months. The child's medical care was compromised and he ended up grossly disabled. In addition, destructive elements were introduced into the family structure at the conclusion of the hospitalization when the baby was placed, under court order, in an institution for the neurologically damaged with visitation by the mother severely restricted.

Problems in the clinical management of this patient arose because the mother was a devout member of the Holiness Church who believed that her baby was ill because possessed of an evil spirit or demon. She brought the baby to the hospital only because the father insisted. She herself believed that it was a sin to do so since healing could come only in response to prayer. Moreover, since she and the father were not wed (and non-married sex was condemned by the

church) the specter of illness sent by God as punishment for sin also hovered in the background. Her lack of trust in the orthodox health care system (as opposed to belief in the Divine Healer) was confirmed when the child did not get better with treatment, and she tried to take him home. The hospital then appealed to the judicial system of the state of Florida on the grounds that the child's life was being endangered by the religious beliefs of the family. The medical record described family members as "fanatic in their religious beliefs," invoking frequent "ritualistic" prayers around the crib. The formal description of the mother by the social worker captured the picture well:

> Affect is animated when she speaks of the boy. She becomes very verbal during conversations, often injecting phrases such as "Praise Jesus," "Hallelujah" and continually refers to her belief that God will heal the baby.

Following this testimony, the petition of the hospital was granted and emergency protective custody was awarded to the state. Unfortunately, the neurological damage was irreversible despite additional hospitalization, and eventually custodial care was required. Throughout the course the mother denied that the baby had medical problems.

In this case the clinician-scientists prevailed in court, but in reality no one won. There is no doubt that the interpretation by physicians that the baby had been irreparably damaged by the religious beliefs of the family was correct. On the other hand, they themselves recognized that they had not done well and stated that "disparate value systems of the hospital staff on one hand and the family on the other resulted in the breakdown of effective communication and led to feelings of bitterness and anger on both sides." They concluded that to act morally in this situation they should have dealt differently with the family, utilizing compromise and reciprocity. For example, the medical staff might have allowed religious ritual (including prayers and chants) to have been carried out at the bedside without restraint in exchange for allowing the baby to remain in the hospital. They thought they should have asked the family minister's "help in healing the child" without condescension or manipulation. In essence they would have said to the religious family and their advisors "you approach God directly for healing and at the same time we can be used of Him to help with the medicine He has allowed us to learn." In short, to behave morally, means not to attempt to overcome or destroy religious beliefs but to work around or even through them. Such an approach is not cynical or hypocritical, even if the physician

finds a particular religious belief naive or abhorrent, if the aim is to help a sick and otherwise helpless patient. The conclusion that religious beliefs should be taken seriously and overturned by legal means only as a last resort has also been recently expressed in a report from the Hastings Center dealing with the problem of blood transfusions of the children of Jehovah's Witnesses.

The second moral dilemma that I want to consider briefly arises when the physician has powerful religious beliefs not shared by the patient. Not at issue here is the sort of quiet religious faith that renders the doctor more kind, compassionate and caring. Nor is it considered a problem when belief influences medical recommendations so long as those beliefs are openly held but not pressed. One would not likely consult a Roman Catholic obstetrician to obtain birth control pills, but one would presumably not be offended if as a matter of principle he or she did not prescribe them. The problems of concern are those that may arise when the physician feels a need to impose, or at least express, his or her personal beliefs on the patient under care, especially if that patient is seriously ill and facing death.

It is a phenomenon almost exclusively limited to physicians belonging to the evangelical wing of Christianity. Aggressive evangelistic behavior amongst Christians is based on two understandings. First, that they are commissioned to preach the gospel and baptize in this world and second that one who dies without accepting Christ as savior misses the chance to experience the eternal presence of God that is symbolized by the word Heaven. In my experience most such physicians are highly idealistic, genuinely interested in their patients and motivated to share that which has brought them peace and happiness. The problem is that the faith tends to be offered under inappropriate conditions, cast in terms of "you ought to believe this" rather than "this is what I believe." Often there is a coercive element, even when it is not intended, simply because the physician is directing medical care and the patient is, of necessity, in a dependent posture. Thus, a discussion which might be appropriate between equals in good health may be totally inappropriate when one partner to the dialogue is handicapped by sickness, weakness, dependence or even fear. Stated simply, use of illness to manipulate the religious beliefs of another is unethical, immoral and totally unacceptable even when motives are good and pure.

The question must then be asked: Is religion a forbidden subject between patient and physician? The answer to this question will

obviously be influenced by one's view of religion in general. A lively exchange on this issue has been recently published in the *Journal of Consulting and Clinical Psychology*. A. E. Bergin opened the dialogue with a carefully stated but nonetheless sharp attack on the functional exclusion of religion from psychotherapy. He noted that "an examination of 30 introductory psychology texts turned up no references to the possible reality of spiritual factors" and pointed out that the words *God* and *religion* were conspicuously absent from all indexes. "Psychological writers," he wrote, "have a tendency to censor or taboo in a casual and sometimes arrogant way something that is sensitive and precious to most human beings." Bergin particularly objected to the concept that exclusion of religion and religious discussion leads to a value-free therapy when in fact those who exclude religious factors often establish goals that are not neutral but actively hostile to theistic systems of belief. He found this a peculiar situation when all the evidence points to the fact that a majority of the American population is theistically oriented. He concluded that "religion is at the fringe of clinical psychology when it should be at the center." The counter attack was immediate. G. B. Walls wrote: "His [Bergin's] suggestion that there be 'acceptance of (divine) authority' in making value judgments is a potentially dangerous notion that could result in the assertion of absolutes without justification." A. Ellis argued strongly against *any* consideration of religion in psychotherapy (and presumably medicine in general) stating: "The emotionally healthy individual is flexible, open, tolerant, and changing, and the devoutly religious person tends to be inflexible, closed, intolerant and unchanging. Religiosity, therefore, is in many respects equivalent to irrational thinking and emotional disturbance. Since it is people's biological as well as sociological nature to invent absolutes and musts, they had better minimize these tendencies, even if they cannot totally eliminate them. The less religious they are, the more emotionally healthy they will tend to be."

As indicated by these remarks the role of religion and the appropriateness of allowing religious dialogue between patient and physician is controversial. Having said this, I want to state that in my opinion such dialogue is not only permissible but on occasion nonoptional if serious illness is present, if the patient is experiencing the sort of primal questions alluded to earlier, and if the whole person rather than the disease is to be dealt with. Patients have fears and anxieties, and those fears and anxieties in the seriously ill are often about death. If they are felt but not expressed, they tend to be more

debilitating and terrifying than if they are discussed, even when the discussion provides no final answers. A fairly recent experience from my own medical service may illustrate:

A young woman was admitted with a distended abdomen stretched tight with fluid. Such an accumulation of fluid is most often due to cirrhosis of the liver secondary to alcoholism or previous hepatitis, but hers was not. She had a rare disease called paroxysmal nocturnal hemoglobinuria, which had caused clotting of the blood in the veins draining the liver with the result that fluid oozed from its surface into the abdominal cavity. Treatment of this condition is ineffective and the outlook is grim. The facts had been conveyed to her in a general way. Each day on rounds I found her crying and depressed but unwilling to talk. One afternoon when I came she had a visitor who was dressed in a postman's uniform. She introduced him as her pastor. He said to me: "She's having a hard time dealing with this happening to *her.*" To which, almost without thinking, I responded: "The rain falls on the just and the unjust." The postman-pastor's face lit up and he said: "Hark, did I perceive a scripture?" After I acknowledged that I knew something about the Bible, the patient began, without restraint, to identify her fears of death and the means of her dying. She further explained that she had been reluctant to voice her fears before, thinking that as a doctor I wouldn't understand her need to talk about death, death anxieties and God. Her defenses against self-revelation became unnecessary when it was perceived that she would be heard with sympathy. Her disease was not changed by this discourse; it still proceeds inexorably. But her illness is lighter as a result and she is now more well even as she continues sick; i.e., fear is no longer her sole emotion.

If one is to permit religious dialogue between physician and patient, what are the rules that would allow it to take place ethically? I would like to suggest four guidelines.

(1) Such dialogue may take place but does not have to take place; either physician or patient may be unequipped or unready to enter in.

(2) Dialogue must be invited by the patient, not imposed by the physician. For example, in the case just cited a clue was picked up by the patient from the physician's conversation; the questions verbalized in response constituted the invitation to communicate at the serious level.

(3) The physician must be open, non-judgmental and honest. He will often be required to say "I don't know." He or she may share his or her own religious beliefs as being personally valuable and helpful

but must not insist that they be considered ultimate truth by the one with whom they are shared. Importantly, the non-religious physician may enter into religious dialogue and help simply by caring and listening whether he considers the patient's thoughts, questions and beliefs rational or irrational.

(4) Whatever its nature, the purpose of the dialogue should be burden-lifting or burden-sharing, not burden-producing. One cringes to hear, no matter how well-meaning, a statement like "If you have sufficient faith, you'll get well." It's tough enough to be sick without having to consider as a cause inadequacy or failure in the realm of personal religious belief. The foundation rule of medical practice also applies to religious discussion: *primum non nocere* (first, do no harm).

In conclusion, I have tried to indicate this afternoon that medicine and religion are related in a bond which cannot be ignored but which also poses ethical problems. I believe it to be immoral to ignore the religious beliefs of another, particularly the ill person under one's care. I also believe it immoral to impose religious beliefs in overt or covert ways. In between there is an enormous freedom to share personhood—and in sharing both physician and patient may find that they grow.

For me personally the ancient prayer of the great Jewish physician Maimonides serves as a useful guide. He addressed the Deity thusly:

> Preserve my strength, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the human being alone. Let me be intent upon one thing, O Father of Mercy, to be always merciful to thy suffering children.

That's a good and moral way in which to go.

N E C R O L O G Y

DAVID WENDELL GUION

1892 - 1981

DAVID WENDELL GUION WAS BORN DECEMBER 15, 1892, IN Ballinger, and throughout his lifetime was never far from his native Texas, which he loved. His father was a lawyer, his mother a singer and pianist, and he grew up hearing songs of Texas and the South. (One of his ancestors was the Governor of Mississippi.) From his boyhood he loved music, and in support of his decision to pursue music as a career his parents sent him to Vienna to study with Leopold Godowsky at the Royal Conservatory. Following the outbreak of World War I, he returned to the states and began to lay the groundwork for his career as a composer.

Throughout the 1920s and 1930s he was composing and performing music which reflected his native land, Texas. His setting of "Home on the Range" was performed for the first time in his New York production, "Prairie Echoes." It became a favorite of President Franklin Roosevelt and the nation. In 1936 he was commissioned to write "Cavalcade of America" for the Texas Centennial Celebration and in 1950 he received a commission from the Houston Symphony. For them he wrote the "Texas Suite," which he completed in 1952. His wide range of compositions number over two hundred published works and include orchestral suites, music for ballets, piano pieces, vocal songs, and religious selections. They have been performed by musicians around the world.

He is well known for his American folk music which includes not only the ever popular "Turkey in the Straw" and "The Arkansas Traveler," but also the "Country Jig in C" and "Country Jig in D," "The Lonesome Whistler," "The Harmonica Player," "Jazz Scherzo," "The Barcarolle," "The Scissors Grinder," "Valse Arabesque," and the "Mother Goose Suite." He was a master at musically representing the history and heritage of early Texas with such works in this vein as "Ride Cowboy Ride," "The Bold Vaquero," "Lonesome Song of the Plains," "Prairie Dusk," and the "Texas Fox Trot." A collection of his waltzes, "Southern Nights," was used in the movie, "Grand Hotel."

Guion was a member of the American Society of Composers, Authors and Publishers, Texas Composers Guild, and the Texas Teachers Association. Although his greatest desire was to compose, he was a dedicated and inspiring teacher and always found time to share his gifts with those around him. His teaching career spanned over sixty years and influenced young musicians at numerous colleges and conservatories including Fort Worth Polytechnic College, Daniel Baker College, Fairmont Conservatory, Chicago Musical College, and Southern Methodist University.

At his passing he left his large collection of antiques, glassware, paintings, art objects, and archives to the Festival-Institute at Round Top. Part of the collection is now housed in the historic Menke House on Festival Hill, and a museum room named in David Guion's honor is included in the master plan development for the Festival-Institute campus. The museum room will focus upon his musical life and heritage and include his piano, and an exhibition of his archives.

David Wendell Guion was a musicologist, composer, teacher, and friend of Texas. His accomplishments are vast and match the tireless giving spirit, goodwill, and brotherhood that he exhibited throughout his lifetime. These accomplishments are a legacy to Texas, a memorial to him, and a reminder of his joy of life, evident to all of us who had the privilege of knowing him and sharing in his active and spirited musical life. He died in Dallas on October 17, 1981.

—J. D.

ROBERT GERALD STOREY

1893 - 1981

EARLY IN THIS EVENTFUL CENTURY, A BOY NAMED ROBERT GERALD STOREY lived in the tiny East Texas community of Arp down the road a little from his birthplace on December 4, 1893, of White Rock. His father was the beloved country physician who taught his son to be involved in the concerns of the human condition. Calling Dallas home for most of his years, he produced an incredible range and volume of works in a lifetime of commitment to making the world a better place for his having been a vigorous part of it.

As Senior Partner of the law firm of Storey, Armstrong & Steger, as founding genius and President of the Southwest Legal Foundation and as Dean of the Southern Methodist University School of Law,

he was recognized for years as one of the nation's most astute attorneys and educators. He made outstanding contributions as a business executive, serving as a director of several national corporations. He was a soldier, a visionary leader of the organized bar, a friend and counselor of presidents, author of three books, a dedicated churchman and public servant of both his state and nation, and, indeed, of the world.

Dean Storey's *public* services included the following varied activities: Assistant Attorney General of Texas for Criminal Appeals, 1921-1923; Member, National Executive Committee, American Legion, 1921-1922; Member, Board of Regents, University of Texas, 1924-1930; Governor, Kiwanis Club, Texas-Oklahoma District, 1931; President of Park Board, City of Dallas, 1938-1941; Executive Trial Counsel for United States, Nuremberg, Trial of the Major Axis War Criminals, 1945-1946; Member, Commission to Reorganize Executive Branch of United States Government *(Hoover Commission),* 1953-1955; Advisor to Korean Government on Judicial System and Legal Profession, 1954, and to Korean Legal Center, 1959-1964; State Department representative in Far East and Middle East to assist legal profession of friendly free nations, 1954-1955; special mission for State Department to confer with officials, and lecture to bar associations and universities in Sub-Sahara, Africa, on Constitutional Law and Civil Rights, 1963; Member and Chairman, Board of Foreign Scholarships (Fulbright Commission), 1956-1962; Member and Vice-Chairman, United States Civil Rights Commission, 1957-1963; Chairman, Citizens Advisory Committee, Texas Constitutional Revision, 1956-1960; Special Counsel to State of Texas in Investigation of the Assassination of the late President Kennedy and related events, 1963-1964; Member and Vice-Chairman, Atlantic-Pacific Interoceanic Canal Study Commission, 1965-1970; Member, President's Commission on Law Enforcement and Administration of Justice, 1965-1967; Chairman, Electoral College Commission, American Bar Association, 1966-1968; Chairman for United States, World Peace Through Law Center, 1947-72; Chairman, Advisory Group for the Establishment of an International Criminal Court, 1971-72; Chairman, Texas Constitutional Revision Commission, 1967-68; Member of Council, Religious Heritage of America; Member, Board of Trustees, Southern Methodist University.

After serving as President of the Dallas Bar Association in 1934, he was President of the State Bar of Texas, 1948-1949; American

Bar Association, 1952-1953; Inter-American Bar Association, 1954-1956. He has been a member of Council of the International Bar Association, and was an Honorary member of Canadian, Peruvian, Mexican, Argentinian, Korean, Japanese, Australian, Ryukyuan and various State Bar Associations.

He served during World War I as a Second Lieutenant in Heavy Artillery, and during World War II as a Colonel in the Air Force.

Many honors paid to Dean Storey included the following: Linz Award, 1956, as outstanding civic leader of Dallas; American Bar Association Gold Medal, 1956, for contribution to advancement of jurisprudence; decorations of the Bronze Star for service on War Crimes Commission in Bulgaria, Legion of Merit for combat intelligence service in Mediterranean theater of operations, U. S. Medal of Freedom, and French Legion of Honor, for services in trial of major Axis war criminals, Nuremberg; Civic Leadership Award, Federal Bar Association and Dallas Federal Business Association, 1957; Headliner of the Year Award, 1959, Press Club of Dallas; Salesman of the Year Award, Dallas Sales Executive Club, 1959, and Life Membership, 1970; Anti-Defamation League Award, B'Nai B'Rith, 1959; Second Order of the Sacred Treasure, Japanese Government, 1961; President's Cultural Medal, Korea, 1964; St. Thomas More Award, St. Mary's University, 1965; Man of the Year, Times Herald Magazine, Dallas, Texas, 1966; Distinguished Alumnus Award, Southern Methodist University, 1969; Outstanding Citizen Award, League of Women Voters, 1969; World Lawyer Award, World Peace Through Law Center, Bangkok, Thailand, 1969; and Honorary Member, Louisiana State Law Institute, 1972.

Among the universities that have awarded Dean Storey honorary degrees are Texas Christian University, Laval University (Quebec), Drake University, and Southern Methodist University—all having conferred the Doctor of Laws; Rikkyo (St. Paul's) University, Japan, and University of the Ryukyus, Doctor of Humanities; and Chungang University, Korea, Doctor of Civil Law.

An elder in the East Dallas Christian Church, he served as First Vice President of the International Convention of Christian Churches (Disciples of Christ) in 1960-1961. He received the Layman of the Year Award in 1961 at the Washington Pilgrimage and received the Protestant Layman Citation from the National Conference of Christians and Jews in 1964.

Dean Storey was an honorary member of Phi Beta Kappa and the Order of the Coif, and, not least, former President of the Texas Philosophical Society.

The late President Herbert Hoover once commented, "Robert G. Storey: great teacher, great lawyer, great public servant, great citizen, great friend, great American." He died in Dallas on January 16, 1981.

—W. M. T.

ANDREW JACKSON WRAY

1901 - 1981

ANDREW JACKSON WRAY WAS BORN IN WACO, TEXAS, JANUARY 11, 1901, the eldest of five sons of Mr. and Mrs. R. D. Wray. His father was a cotton buyer and shipper who soon moved his family to Hearne near the Brazos River. A tall, powerful athlete, Jack Wray enrolled at Southwestern University with the hope of playing football. However, when in 1917 the United States was led into World War I, he joined the Army at age 17, and that was the end of his formal education.

Out of the military service in 1919 he went to work in the oil fields for a time, until in the early Twenties he came to Houston and found a job with Cravens, Dargan and Company, the general insurance agency. From then on he spent his business career in the fire and casualty insurance field, a total of almost sixty years, except for a three-year tour of duty in the Nation's service in World War II as a Captain in the Air Force. He had grown with Cravens, Dargan for over twenty-five of those years, when he resigned in 1951 to set up his own agency. This developed rapidly so that in 1959 with two younger associates he organized the firm of Wray, Couch and Elder which flourished for ten years before merging into the national insurance company of Marsh and McClennan, Inc. of New York, with the three partners holding top positions.

Jack Wray's skill in salesmanship was founded on thorough knowledge of his product and also on his capacity for friendship with all sorts of people, high and low. A dodger issued by his firm carried the message, "This poor old Earth has need of mirth." In tune with that he regularly filled his pockets every morning with pens and pencils, each carrying a printed aphorism that reflected his delightful sense of humor. He passed them out by hand to everybody he might

meet, and it was done with such a flair that even strangers fell under the spirit of it. The following few samples might suggest that a collection of them should fit a museum:

"A man's best friends are a good wife, an old dog and ready money."

"Women are wonderful and there ain't no substitute."

"Nothing is often the clever thing to say."

In 1926 Jack Wray married Miss Margaret Cullinan of Houston. Their daughter Lucie is the wife of Anderson Todd, Professor of Architecture at Rice University. There are two grandchildren, both college graduates. It has been a close family devoted to their homes and to the Wray ranch of some 400 acres a few miles from Columbus in Colorado County. Jack himself though an outgoing person who liked people and relished good company had his private side and was jealous of his quiet time. He became a thoughtful reader of serious literature and his unusually retentive mind stored up material for reflection and retrieval in conversation. That represented the college training that he had missed and it made him a well educated gentleman indeed.

An untaught, bounding Clydesdale style, tennis player, Jack was leader of an informal group that for years met every Saturday afternoon and Sunday morning. At the same time he belonged to a golf club but didn't play, he belonged to a duck hunting club but never fired a shot, he delighted in his ranch, was proud of his cattle, but never rode a horse.

But Wray had acquired a problem. As a salesman dealing with interesting people and entertaining generously he drank too much. He had for years in social contacts been a happy drinking man, well adjusted to it, or thinking he was. Finally at age 57, encouraged by a wonderfully patient and gentling wife, he recognized the situation and confronted it. That sent him into seclusion, and when he emerged he was dry—permanently so. Thereafter, as long as he lived, he set himself to help others to overcome that addiction. He joined Alcoholics Anonymous, attended regular meetings year after year, and gave testimony wherever he might be, across the nation, at the Bohemian Grove, or in Europe where he visited frequently. In Houston he was always ready to go to the assistance of others, offering aid and comfort to sufferers, as well as to scores of distracted parents and spouses—counseling, following up, and converting. Many a man and woman owe their futures to this man's example and knowledgeable coaching. After eighty full years he died March 21, 1981.

—W. A. K.

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FRANK WILSON WOZENCRAFT
WILLIAM EMBRY WRATHER
ANDREW JACKSON WRAY
RAMSEY YELVINGTON
HUGH HAMPTON YOUNG